AMENDMENT OF SOLICITATION / MODIFICATION OF CONTRACT

1. HCA Solicitation Number	Page of Pages	
CFSA-10-H-0016	1	5

2. Amendment/Modification Number	3. Effective Date	4. Requisition/Purchase Request No.	5. Solicitation Caption
CFSA-10-H-0016-A002	See Block 16C		Case Management and Family Based Foster Care Services

6. Issued by: Code	7. Administered by (If other than line 6)
Child and Family Services Agency Contracts and Procurement Administration 955 L'Enfant Plaza, S.W., Suite 5200 Washington, DC 20024	Child and Family Services Agency Contract Monitoring & Performance Improvement Admin. Child Placement Agency Monitoring Division 955 L'Enfant Plaza, SW, Room 1008 Washington, DC 20024

8. Name and Address of Contractor (No. street, city, county, state and zip code)	9A. Amendment of HCA No.
	CFSA-10-H-0016
	9B. Dated (See Item 11)
	April 21, 2010
	10A. Modification of Contract/Order No.
Code DUNS: TIN FEIN:	10B. Dated (See Item 13)

11. THIS ITEM ONLY APPLIES TO AMENDMENTS OF SOLICITATIONS

☒ The above numbered solicitation is amended as set forth in item 14. The hour and date specified for receipt of Offers ☒ is extended ☐ is not extended. Offeror's/Bidder's /Provider's must acknowledge receipt of this amendment prior to the hour and date specified in the solicitation or as amended, by one of the following methods: (a) By completing Items 8 and 15, and returning 2 copies of the amendment: (b) By acknowledging receipt of this amendment on each copy of the offer submitted; or (c) BY separate letter or fax which includes a reference to the solicitation and amendment number. FAILURE OF YOUR ACKNOWLEDGMENT TO BE RECEIVED AT THE PLACE DESIGNATED FOR THE RECEIPT OF OFFERS PRIOR TO THE HOUR AND DATE SPECIFIED MAY RESULT IN REJECTION OF YOUR OFFER. If by virtue of this amendment you desire to change an offer already submitted, such may be made by letter or fax, provided each letter or telegram makes reference to the solicitation and this amendment, and is received prior to the opening hour and date specified.

12. Accounting and Appropriation Data (If Required) *To be cited on individual orders issued on behalf of participating agencies*

13. THIS ITEM APPLIES ONLY TO MODIFICATIONS OF CONTRACTS/ORDERS, IT MODIFIES THE CONTRACT/ORDER NO. AS DESCRIBED IN ITEM 14

	A. This change order is issued pursuant to (Specify Authority): The changes set forth in Item 14 are made in the contract/order no. in item 10A.
	B. The above numbered contract/order is modified to reflect the administrative changes (such as changes in paying office, appropriation data etc.) set forth in item 14, pursuant to the authority of
	C. This supplemental agreement is entered into pursuant to authority of:
	D. Other (Specify type of modification and authority)

E. IMPORTANT: Contractor ☐ is not ☒ is required to sign this document and return 2 copies to the issuing office.

14. Description of Amendment/Modification (Organized by UCF Section headings, including solicitation/contract subject matter where feasible

1. Attachment J.1.1, Page 14, No. 12, BUSINESS PLAN FORM, ORGANIZATION AND CONTENT

Delete: One original and four (4) copies of the written business plans shall be submitted in two parts, titled "Business Plan" and "Price".

Substitute: One original and four (4) copies of the written business plans shall be submitted in three parts, titled "Human Care Qualifications Record", "Business Plan" and "Cost and Price".

3. Attachment J.1.1, Item Nos. 13.3.1 and 29, BUSINESS PLAN SUBMISSION DATE AND TIME is hereby extended to Monday, June 7, 2010 by 2:00 P.M. local time.

Except as provided herein, all terms and conditions of the document is referenced in Item 9A or 10A remain unchanged and in full force and effect.

15A. Name and Title of Signer (Type or print)		16A. Name of Contracting Officer Tara Sigamoni	
15B. Name of Contractor (Signature of person authorized to sign)	15C. Date Signed	16B. District of Columbia Tara Sigamoni (Signature of Contracting Officer)	16C. Date Signed 5/18/10

14. Description of Amendment/Modification (Organized by UCF Section headings, including solicitation/contract subject matter where feasible).

4. Attached is the revised Attachment J.1.3, Definitions of Provider Scorecard Measures.

5. Delete Sections B.5 through B.14 and pages 6 through 11 in its entirety, substitute with the attached revised Sections B.5 through B.14, pages 6R through 11R.

6. Delete Sections C.1 through C.11, pages 12 through 49 in its entirety, substitute with the attached revised Section C.1 through C.11, pages 12R through 49R.

7. Page 68, Subsection H.9.4.3.1.D delete in its entirety, substitute with the following:

   H.9.4.3.1.D Supervisors, Program Managers and Directors shall receive annually a minimum of 24 hours of structured in-service training.

8. Listed below are the response to questions that was submitted to the Contracts and Procurement Administration in writing as Request for Information, RFI Q01 through Q17.

Q01

Question: Page 27 – C.6.11.1.4 states the following, "Weekly visits between child/youth and siblings", has this benchmark changed? Right now siblings are required to visit twice a month - not weekly.

Response: See the revised Section C attached to this Amendment.

Q02

Question: Is the CQR for new providers and current providers?

Response: All Providers (new and current) are required to submit the Human Care Qualifications Record - Part I, Business Plan - Part II and the Cost and Price - Part III.

Q03

Question: Do we submit a separate CQR each program or is it one per agency?

Response: Providers must submit one comprehensive Human Care Qualification Record for all programs. Individual business plans, Cost and Price must be submitted for each specific program.

Q04

Question: Is there a limit to the number of pages for the Business Plan?

Response: No, there is no limitation to the number of pages. However, all Providers (new and current) must ensure their submissions are complete, accurate and comprehensive. Providers must use their best judgment in submitting their packages.

14. Description of Amendment/Modification (Organized by UCF Section headings, including solicitation/contract subject matter where feasible).

Q05

Question: If we submit one package for each of the program, will they all have the same HCA number?

Response: See response to Q03. The solicitation number remains the same for Parts, I through III and for all program areas. The HCA number will change prior to contract award.

Q06

Question: Is adoption considered a separate CLIN?

Response: No, there is not a distinct CLIN assigned to adoption services. CFSA is seeking to contract with Providers able to achieve permanency for children, of which one of the goals is adoption. CFSA prefers to contract with those able to offer the full range of permanency services.

Q07

Question: Must all agencies provide adoption services?

Response: No, it is not required, as stated in response Q6, CFSA prefers that Providers are able to achieve all permanency goals for children.

Q8

Question: New benchmark measures.

a. # pre-placements health screens
   i. Chronic absconders - will this require a new pre-placement screen each time they are gone more that 72 hours?
   ii. What about children on pre-placement visits?
b. Children with two or fewer moves
   i. Chronic absconders – will each re-entry be counted as a move?

Response:

a. # pre-placements health screens
   i. Yes, this will require a new pre-placement screen
   ii. No, a pre-placement health screen is not required for children on pre-placement visits.
b. Children with two or fewer moves
   i. Yes, each re-entry will be counted as a "move" or placement change.

Q9

Question:

1. Section C.3.2: Are we to have a data collecting system for the federal government outcomes and indicators?
2. Are we also to internally track the Modified Scorecard which is already being tracked in FACES?

Response:

1. Yes, the statement of work specifies that the Provider shall develop and maintain its own Quality Assurance System that collets and analyzes data on performance indicators and outcomes outlined in the solicitation.
2. The Provider, as part of its Internal Quality Assurance System, needs to be tracking progress on these scorecard indicators. The Provider may decide to use FACES data for this activity.

14. Description of Amendment/Modification (Organized by UCF Section headings, including solicitation/contract subject matter where feasible).

Q10

Question: Does each CLIN need its own business plan?

Response: Yes, the prospective Provider needs to submit a separate business plan for each CLIN.

Q11

Question: All placements including changes within the same Provider agency shall occur through CFSA Placement Administration? What about emergency placements?

Response: See the revised Section C attached to this Amendment.

Q12

Question: Sections C.6.11.1.1 through C.6.11.1.4 differs from the benchmarks, which will be measured?

Response: See the revised Section C attached to this Amendment.

Q13

Question:
a. Section C.9.3.1.2.1 Traditional placements:
No more than 3 in a single foster home, assuming the intent is for this to be a two parent home?
b. Section C.9.3.3.5.2 Therapeutic placements:
No more than 2 in a foster home at any time. This means a single parent home can now Have two therapeutic children?

Response: a. and b: See the revised Section C attached to this Amendment.

Q14

Question: Section H.9.4.1.2.E: Can we not use licensed BSW's anymore?

Response: BSW's maybe used as Social Worker Aides or Assistants. See Section H.9.4.1.2.F.

Q15

Question: Section H.9.4.1.3: Behavioral Specialist – Is this a new position?

Response: Yes, this position should serve to ameliorate the incidence of placement changes requests by enhancing the capacity of foster parents to manage behavior challenges posed by children.

14. Description of Amendment/Modification (Organized by UCF Section headings, including solicitation/contract subject matter where feasible).

Q16

Question: Section H.15.1: Are the services such as mentoring and tutoring that we purchase for the combined service line item considered contracts under this section? These services are to be Provided in an approach that is the most cost efficient, yet effective, for children serviced by the Provider.

Response: Mentoring and Tutoring Services purchased through the combined service line item are considered contracts under this section. The solicitation outlines that the services can be accessed through CFSA's Office of Clinical Practice, via the child's school, community based Providers, or on a volunteer basis. The Provider should propose an innovative approach that keeps these costs contained.

Q17

Question: Section H.9.4.4.1: Does the baby occupy one of our contracted slot?

Response: Delete H.9.4.4.1 paragraph in its entirety, substitute the following paragraph.

The Provider of Traditional and Teen Parent Family Based Foster Care shall assign caseloads to each Case Managing Social Worker in adherence to the Amended Implementation Plan guidelines of fifteen (15) cases per Case Managing Social Worker. The Provider may maintain caseloads with fewer cases, but the AIP parameters shall serve as the maximum numbers allowable. The Provider shall take dependent. The dependent child of a Teen Parent occupies 50% of a contracted slot, with per diem paid to the Provider in accordance with this partial slot arrangement.

8. Delete Section H.7 in its entirety, substitute the following Section.

H.7 AMERICANS WITH DISABILITIES ACT OF 1990 (ADA)

H.7.1 During the performance of the human care agreement, the Provider and any of its subcontractors shall comply with the ADA. The ADA makes it unlawful to discriminate in employment against a qualified individual with a disability. See 42 U.S.C. § 12101 et seq.

H.7.2 CFSA family based contracts must ensure that the Providers assess the needs of clients and provide auxiliary aids and interpreters as required to ensure effective communication with the clients.

9. Additional responses to those unmentioned questions will be forthcoming by Amendment.

REVISED SECTION B
PAGES 6R THROUGH 11R

B.5 PER DIEM

B.5.1 The District shall pay the Provider for the actual number of children placed with the Provider over the course of a month, based on the Per Diem rate set forth in Section B.4 of this HCA. The per diem rate will be paid per child, per day and invoiced to the District on a monthly basis, per the instructions outlined in Section G of the HCA. The Provider need only provide the services outlined in Section C of the HCA to be paid the per diem rate. The per diem rate is a pre-negotiated rate between the Provider and the District government.

B.5.2 Example: The District will utilize the following formula each month to determine how much it will pay the Provider for the Per Diem Services: f = (c X d X e) where "f" represents the total payment for Per Diem Services; "c" represents the number of children actually placed with the Provider over the course of the month; "d" represents the Per Diem rate set forth in the HCA; and "e" represents the number of days in the month. Assuming the actual number of children served is 35 and the Provider's Per Diem rate is $100 and the month is 30 days long, under the above formula, the District will pay the Contractor $105,000 for Per Diem Services (calculated by multiplying 35 children X $100 Per Diem X 30 days).

B.5.3 The Provider may include in the per diem, the costs of direct care services to the child and their related costs. These direct care costs include the wages and salaries of the personnel detailed in the Staffing Array outlined in Section H.9.4.1; fees for approved consultants/experts providing direct care services to the child; and the related support costs for these staff. Additional personnel and their related support costs may be included, subject to the review, negotiation and approval of CFSA.

- Schedule 1 Wages/Salaries
- Schedule 3 Consultants/Experts

B.5.4 Additionally, the per diem may include the portion of the Budget Schedules 2 and 4 through 11 costs related to the qualifying personnel identified in Schedules 1 and 3. All Schedule 8 Client Costs must be included in the per diem, inasmuch as these are child-specific, reimbursable, direct service costs.

- Schedule 2 Fringe Benefits
- Schedule 4 Occupancy
- Schedule 5 Travel/Transportation
- Schedule 6 Supplies and Minor Equipment
- Schedule 7 Capital Equipment/Outlays
- Schedule 8 Client Costs
- Schedule 9 Communication
- Schedule 10 Other Direct Costs
- Schedule 11 Indirect Cost/Overhead

B.6 REIMBURSEABLE COST

The Provider will be reimbursed on a cost reimbursable basis for specific costs outlined in Section B.9 that are supported and substantiated by the provider with a ceiling amount set forth in CLIN's 0001 thru 2005. The Provider cannot mark-up the cost reimbursement allowable expenses on this HCA with indirect cost of overhead and general and administrative cost. Profit may not be charged against cost reimbursement expenses under this HCA. Tangible items charged under this cost reimbursement CLIN (such as vehicles, computers, or equipment) will become the property of the District of Columbia.

B.7.1 CLIN's 0001 thru 0005, 1001 thru 1005 and 2001 thru 2005, Section B of the HCA set forth for the ceiling amount for the combined services element of the HCA ("ceiling").

B.7.2 The amount for performing this cost element of the HCA shall not exceed the ceilings specified in CLIN's 0001 thru 2005.

B.7.3 The Provider shall notify the Contracting Officer's Technical Representative (COTR), in writing, whenever it has reason to believe that the total amount for the performance of this HCA will be either greater or substantially less than the ceilings.

B.7.4 As part of the notification, the Provider shall provide the COTR a revised estimate for the ceilings for performing the HCA.

B.7.5 The District is not obligated to pay the contractor for amounts incurred in excess of the ceilings specified in the HCA and the contractor is not obligated to continue performance under this HCA (including actions under the Termination clauses of this HCA) or otherwise incur amounts in excess of the ceilings specified in the HCA, until the contracting officer notifies the contractor, in writing, that the ceilings have been increased and provides revised ceilings for performing this HCA.

B.7.6 No notice, communication, or representation in any form from any person other than the contracting officer shall change the ceilings. In the absence of the specified notice, the District is not obligated to pay the contractor for any amounts in excess of the ceilings, whether such amounts were incurred during the course of the HCA performance or as a result of termination.

B.7.7 If the contracting officer increases the ceilings, any amount the contractor incurs before the increase that is in excess of the previous ceilings shall be allowable to the same extent as if incurred afterward, unless the contracting officer issues a termination or other notice directing that the increase is solely to cover termination or other specified expenses.

B.7.8 A change order shall not be considered an authorization to exceed the applicable ceilings, unless the change order specifically increases the ceilings.

B.7.9 At any time or times before final payment and three (3) years thereafter, the contracting officer may have the contractor's invoices or vouchers and statements audited. Any payment may be reduced by amounts found by the contracting officer (1) not to constitute allowable payment as adjusted for prior overpayments or underpayments, or (2) not to constitute allowable, allocable, or reasonable costs. This section is subject to the Disputes provision of the HCA.

B.8 COMBINED SERVICES LINE ITEM

As per Section C, the Scope of Services, the Provider shall be responsible for the provision of case management and family based foster care services, as well as pay for necessary goods and services for children, biological, foster and pre-adoptive families. The Combined Services Item is a specified dollar amount set aside to compensate the Provider for those costs that are not included in the daily rate (per diem) paid by CFSA. In addition to the per diem, the Provider may receive a variable amount on a monthly basis during the period of performance based on the Provider's performance on a standardized set of performance indicators. The Provider will only be compensated up to the maximum amount of the Combined Services Line Item based on the finalized scorecard.

B.9 COST COMPONENTS OF THE COMBINED SERVICES ITEM

The Provider may utilize compensation via the Combined Services Item to cover the costs incurred in full or part of any item in Budget Schedules 1 through 7; and Schedules 9 through 11, which cannot be included in the per diem. The Provider may include costs in the Combined Services Item that are determined to be not directly related to the provision of direct care services to the child. Additionally, the Provider may include in the Combined Services Item the estimated cost of any other services for which a specific price/rate cannot be readily determined; or any estimated, unforeseen costs.

B.10 PERFORMANCE INDICATORS: PROVIDER SCORECARD

B.10.1 The Provider will be compensated a portion of its allocated Combined Services Item contingent upon attainment of a set of benchmarks or performance indicators outlined below, and illustrated in the Provider Scorecard in Section B.12. The performance indicators relate to practice benchmarks found in federal child welfare standards and the LaShawn A. v. Fenty Amended Implementation Plan (AIP).

B.10.2 The following outlines the performance indicators comprising the Provider Scorecard. There are seven (7) indicators measured on a monthly basis, and two (2) additional indicators measured on a quarterly basis. The percentage indicated for each is the minimum target benchmark to be achieved.

Monthly Indicators

B.10.2.1 Percentage of children remaining at home who had at least twice monthly visits with a social worker (with at least one visit in the home) (50%)

B.10.2.2 Percentage of children in foster care who had at least twice monthly visits with a social worker (with at least one visit in the home) (80%)

B.10.2.3 Percentage of children who had at least twice monthly visits with some or all of their siblings (75%)

B.10.2.4 Percentage of children with goal of reunification that had weekly visit with their parents (85%)

B.10.2.5 Percentage of children who had weekly visits with social workers during their first four (4) weeks of placement (90%)

B.10.2.6 Percentage of foster children who had a pre-placement health screening (90%)
i. Chronic Absconder will require a new pre-placement screen
ii. Pre-placement health screen is not required for children on pre-placement visits.
iii. Each re-entry will be counted as a "move" or placement change.

B.10.2.7 Percentage of foster children who had two or fewer placements post case assignment (80%)

Quarterly Indicators

The following performance indicators are more longitudinal in scope, and will be calculated on a quarterly basis. These indicators will be added to the seven (7) monthly indicators, bringing the total number of indicators on a quarterly basis to nine (9).

B.10.2.8 Percentage of children with no re-entries within 12 months of a prior foster care episode (96%)

For this indicator 8, the objective is less than 15% annually, with a 4% quarterly benchmark. Ideally, Providers will have 0% of children re-enter foster care within 12 months of exit.

B.10.2.9 Percentage of children achieving permanency within the past 12 months (15%)

For this indicator 9, the objective is 60% annually, with a 15% quarterly benchmark.

B.11 METHODOLOGY OF COMPENSATION

CFSA will run a monthly management report in the FACES information system that summarizes the Provider's statistical performance on each of the incentivized indicators: seven (7) monthly performance indicators, and an additional two (2) quarterly indicators (for a total of 9 in the third month of each quarter). CFSA will then calculate the total number of applicable cases or each of the indicators. The percentage of cases in compliance, of the total number of applicable cases,

represents the preliminary calculated average performance (CAP) (prior to any applied incentives or disincentives). The Provider's performance on each indicator will then be examined in comparison to the established benchmark for that indicator noted in the following Section B.12. The Provider's CAP on the indicators, plus or minus applicable incentives and disincentives, will determine the final (or reconciled) CAP score, and resulting percentage of the monthly Combined Services Item allocation the Provider will receive.

B.12 CALCULATED AVERAGE PERFORMANCE (CAP)

B.12.1 CFSA's computation of the "calculated average performance", or CAP, is a two-step process. The first step includes dividing the aggregate number of compliance cases by the aggregate number of applicable cases. The second step is to compute the incentives and disincentives earned by the Provider's performance on each indicator. The percentage earned by the Provider is compared with the benchmark percentage to determine by what percentage the Provider has exceeded the desired benchmark; or conversely, fallen below the benchmark. For each percentage point above or below the benchmark, the CAP will be increased and/or reduced by one-tenth of a percent to compute the final CAP.

B.12.2 The following provides an example of a CAP computation based on a sample Provider Scorecard and benchmark scores. The table includes sample monthly and quarterly performance scores, and the narrative explains how CFSA arrives at the final CAP score.

Sample Provider Scorecard

	Applicable Cases	Compliance Cases	Percent	Benchmark	One-tenth Disincentive	One-tenth Incentive	Final Score
In-Home Visitation	20	20	100.0%	50%		5	
Foster Care Visitation	20	20	100.0%	80%		2	
Siblings Visitation	20	15	75.0%	75%			
Parent-Child Visitation	20	15	75.0%	85%	-1		
First 4 Weeks Visitation	20	15	75.0%	90%	-1.5		
Health Screenings	20	15	75.0%	90%	-1.5		
Placement Stability	20	15	75.0%	80%	0.5		
Quarterly Measures							
No Re-Entries Within 12 months	20	20	100.0%	96.0%		0.4	
Achieving Permanency within the past 12 months	20	5	25.0%	15.0%		1.0	
	180	140	77.8%		-3.5	8.4	82.7

Definitions of Scorecard Measures is incorporate by reference as Attachment J.1.3

- In this example, the aggregate applicable cases total 180, and the aggregate compliance cases total 140.
- Dividing 140 by 180 yields 77.8% (140 / 180 = 77.8)

- The Provider has fallen below the benchmark on four indicators totaling (-3.5) as a disincentive mark; and has exceeded the benchmark on four indicators totaling (+8.4) as an earned incentive mark.

- Dividing 140 by 180 yields 77.8% (140 / 180 = 77.8)

- The Provider has fallen below the benchmark on four indicators totaling (-3.5) as a disincentive mark; and has exceeded the benchmark on four indicators totaling (+ 8.4) as an earned incentive mark.

- Applying the (-3.5) one-tenth disincentive and the (+8.4) one-tenth incentive (based on benchmark performance), the Provider achieves a (+4.9) overall incentive yielding a final score of 82.7%. [77.8 + (-3.5) + (8.4)] = 82.7 OR [77.8 + (4.9)] = 82.7

- As a result, the Provider receives 82.7% of the allocated monthly Combined Services Item for that month.

B.13 MONTHLY NOTIFICATION AND RECONCILIATION OF CALCULATED AVERAGE PERFORMANCE (CAP)

B.13.1 CFSA will notify the Provider in writing of its monthly CAP score. The Provider will then have five (5) business days to respond in writing to the Monitoring and Performance Improvement Administration (CMPIA) with any disputes related to the score. The Provider may provide any relevant, mitigating information relevant to the dispute. "Mitigating information" includes, but is not limited to, any official documentation, such as court orders, court reports, treatment records, clinical assessments, and financial invoices.

B.13.2 CFSA will consider the dispute, if submitted in a timely manner, and provide a response within ten (10) business days. CFSA's response will outline any changes, if applicable, to the CAP score as a result of this reconciliation. If there are no changes to the CAP score, CFSA's response will outline the rationale for its denial of the disputed score. If the Provider is still in disagreement with the final CAP score, the parties will meet within (5) five business days to reconcile the differences.

B.13.3 Once the monthly CAP score has been finalized, the Provider invoices CFSA for this eligible portion of that month's Combined Service Item allocation.

B.14 OPEN MARKET QUALIFICATION (SUPPLIES & SERVICES)

B.14.1 If an provider intends to subcontract under this HCA, it must subcontract at least 35% of the dollar volume of this contract in accordance with the provisions of section M.1.1. The prime contractor responding to this HCA shall be required to submit with its business plan, a notarized statement detailing its subcontracting plan. Business Plan responding to this qualification shall be deemed nonresponsive and shall be rejected if the provider intends to subcontract in accordance with the provisions of section M.1.1, but fails to submit a subcontracting plan with its business plan.

REVISED SECTION C
PAGES 12R THROUGH 49R

SECTION C – SCOPE OF SERVICE FOR CASE MANAGEMENT AND FAMILY BASED FOSTER CARE SERVICES

C.1 BACKGROUND

C.1.1 The Government of the District of Columbia's Child and Family Services Agency (CFSA, or the Agency) is charged with protecting children and youth from abuse and neglect; and, for those needing to be removed from their homes, ensuring a foster care placement that can effectively support children and youth in achieving their goals of safety, permanence, and well being.

C.1.2 CFSA plans to purchase performance based, case management and family based foster care from private Agencies, or Providers, utilizing family based foster homes for care of children and youth that have been removed from their natural home due to abuse and/or neglect. CFSA continues to prioritize family based foster care for young and older children alike.

C.1.3 All children and youth deserve a permanent home and the nurture and support of a loving family. CFSA expects family based foster care Providers to achieve timely permanency goals for children and youth referred for case management and foster care services.

C.1.4 Providers of family based foster care services shall provide children and youth with a set of high quality services that include a safe and stable foster care placement with a structured treatment environment that fosters positive child and youth development, and proactive case management work that succeeds in achieving permanence. CFSA expects that family based foster care agencies will meet outcomes as established in this scope of work and will complete requirements set forth by the Adoption and Safe Families Act (ASFA, H.R. 6893), the LaShawn A. v. Fenty Amended Implementation Plan (AIP), and Fostering Connections to Success and Increasing Adoptions Act (Public Law 105-89).

C.1.5 Providers of family based foster care programs shall identify and be responsive to the individual needs of the child or youth and the related service needs of the child's family from the point of initial placement through achievement of his/her service plan and permanency goals. CFSA expects Providers to address the case management needs of children and youth with minimal, if any, placement moves.

C.1.6 This HCA places special emphasis on the establishment and attainment of permanence plans for every child, as well as meeting desired outcomes for safety and well-being.

C.1.7 Achievement of established outcomes set forth in Section C.3 will be monitored on a monthly basis. In addition, designated performance indicators will be incentivized as outlined in Section B of this document. Every Provider will be monitored on three (3) levels to include, general HCA and scope of work requirements, federal outcomes, and incentivized performance indicators.

C.2 CONTINUUM OF PERMANENCY

C.2.1 CFSA will measure Provider Agencies' ability to provide a safe and stable care environment, and achieve permanency and well being goals for children and youth, through a set of outcomes and performance indicators.

C.2.2 The Provider shall deliver proactive case management services that achieve permanency for children and youth through continuous and effective assessment, concurrent case planning and teaming efforts of the assigned Case Managing Social Worker (CMSW). The Provider's case management approach shall pursue reunification as the initial permanency goal, unless compelling and documented reasons make a different permanency goal necessary. The Provider's services shall include the pursuit of permanent resources by diligently seeking, assessing preparing, and supporting permanent families. If efforts toward reunification determine that this is no longer a viable permanency goal, the CMSW, shall shift permanency planning toward guardianship, legal custody, or adoption. The Provider shall follow CFSA guidance on permanency outlined in its "Out-of-Home Practice Protocol".

C.2.3 The Providers shall achieve the full range of permanency goals (reunification, guardianship, legal custody, adoption) for children and youth through its own case management and service resources. CFSA will continue to offer Providers technical assistance.

C.2.4 The Provider shall collaborate in CFSA permanency strategies. The Provider's permanency planning and efforts shall include where appropriate, and defined, the development of permanent connections between children and youth and a significant individual in their life that can serve as a permanent resource for achievement of the permanency goal. Also, CFSA will assign a technical assistance team from the Permanency Opportunities Project (POP) and the Office of Youth Empowerment (OYE) to assist the Provider with permanency efforts.

C.2.5 The Provider shall recruit, train and support a pool of foster homes that provide a treatment environment capable of meeting the child or youth's well being needs, and providing stability while the child or youth's permanency goals are achieved. The Provider's foster parents shall have the capacity to manage and improve emotional and behavioral functioning of children and youth to enable progress toward his or her goals, especially according to those target populations identified in the Provider's business plan.

C.3 PERFORMANCE OUTCOMES AND INDICATORS

C.3.1 The Provider shall ensure case management and supportive services that achieve the established outcomes for children and youth in family based foster care as outlined in this section.

C.3.2 The Providers shall develop and implement a quality assurance system that collects data to measure progress on the outcomes and indicators defined by the federal government for child welfare, as well as those incentivized indicators outlined in the Modified Scorecard in Section B.7.

C.3.2.1 Safety Outcomes

C.3.2.1.1 Reduce recurrence of child abuse and/or neglect.

C.3.2.1.1.A Performance Indicator: Of all children who were victims of abuse and/or neglect during the reporting period, the percentage that had another substantiated report within a 12-month period.

C.3.2.1.2 Reduce the incidence of child abuse and/or neglect in foster care.

C.3.2.1.2.A Performance Indicator: Of all children in foster care during the reporting period, the percentage that were maltreated by a foster parent or facility staff.

C.3.2.2 Permanency Outcomes

C.3.2.2.1 Increase permanency for children in foster care.

C.3.2.2.1.A Performance Indicator: For all children who exited the child welfare system, the percentage that left either to reunification, adoption, or legal guardianship.

C.3.2.2.2 Reduce time in foster care to reunification without increasing re-entry.

C.3.2.2.2.A Performance Indicator: Of all children who entered foster care during the reporting period, the percentage that re-entered care within 12 months of a prior foster care episode.

C.3.2.2.3 Reduce time in foster care to adoption.

C.3.2.2.3.A Performance Indicator: Of all children who exited care in a finalized adoption, the percentage that exited care in: <12 months, 12-24 months, 24-36 months, 36-48 months, > 48 months.

C.3.2.3 Well-Being Outcomes

C.3.2.3.1 Increase placement stability

C.3.2.3.1.A Performance Indicator: Of children in care with the Provider, for the duration of placement with that Provider, the percentage that have maintained stability within one foster care placement setting.

C.3.2.3.2 Performance Indicator: Percentage of children 12 or younger who entered care during the reporting period and were placed in group homes or institutions.

C.3.2.3.2.A Reduce placements of young children in group homes or institutions.

C.4 TARGET POPULATIONS

C.4.1 All children require nurturing, guidance and direction as they attempt to grow and develop through life's stages. Children and youth in foster care will have additional experiences that with focused nurture, care, and a set of services designed to meet their needs, will still progress and reach established goals. Separation anxiety, anger, fear, depression, and other health, mental health, as well as educational challenges are some typical reactions that set the tone for work with children and youth placed out of their homes in foster care. The depth of needs distinguishes the type of care required.

C.4.2 As indicated by the type of business plans that have be submitted and approved by CFSA, the Provider shall provide one or more of the following types of family based foster case services:

C.4.2.1 The Provider of Traditional Family Based Foster Care shall serve those children and youth ranging in age from birth through twenty-one (21) years that present emotions and behaviors typical of abuse and neglect, as described above in C.4.1, but do not present conditions requiring Therapeutic Care (see Section C.4.2.2). This care shall be provided in licensed, family based foster homes.

C.4.2.2 The Provider of Therapeutic Family Based Foster Care shall serve those children and youth ranging in age from birth through twenty-one (21) years that present the need for a more therapeutic milieu as supported by an Axis 1 diagnosis and CFSA-approved clinical justification. The Provider shall, within a period of twelve (12) months or less, stabilize the child or youth, and effectively transition the individual to a less therapeutic level of care, if clinically appropriate. The continued need for placement in this more intense level of care and service shall be demonstrated through documented assessments made by the CMSW, and included as part of the child or youth's Individualized Treatment Plan (ITP). See Section C.6.8 for Service business planning specifics. This care shall be provided in licensed, family based foster homes.

C.4.2.3 The Provider of Teen Parent Family Based Foster Care shall serve pregnant and parenting teens and their children in licensed, family based foster homes. CFSA also seeks Providers that can serve pregnant and parenting teens who are in need of therapeutic care, and are not developmentally appropriate for congregate care independent living programs.

C.4.2.4 The Provider of Specialized Family Based Foster Care shall serve those children and youth ranging in age from birth through twenty-one (21) years that present conditions of developmental disabilities and/or medical fragility (life threatening illness or chronic health conditions described in Section C.6.7).

C.4.2.5 CFSA also seeks family based foster care that specifically serves lesbian, gay, bisexual and transgendered children and youth within Traditional, Therapeutic and Specialized Care programs.

C.4.2.6 CFSA seeks innovative approaches to accommodating the placement of siblings together within family based homes.

C.5 DEFINITIONS

C.5.1 Abscondance – The child or youth is absent from an approved placement due to escape, runaway or truancy status.

C.5.2 Administrative Review – Periodic review for children in foster care and placement alternative services involving all parties in the case to determine the appropriateness of the placement and/or case plan. All children in foster care are to have an administrative review of case progress in accordance with CFSA policy.

C.5.3 Adoption – A Family Court terminates a child or youth's legal rights and duties toward his/her natural parents and substitutes similar rights and duties toward adoptive parents. A financial subsidy may or may not be involved.

C.5.4 Adoption Services – Services provided to facilitate the adoption of children. Services may include recruitment, licensing, home study, training, and retention of adoptive parents.

C.5.5 Agency – the DC Child and Family Services Agency, or CFSA.

C.5.6 Axis 1 Diagnosis – Outlined by the Diagnostic and Statistical Manual of Disorders (DSM-IV), includes all psychiatric diagnoses with the exception of personality disorders and mental retardation.

C.5.7 Behavior Management Plan – A written document that targets the specific problematic behaviors of a child/youth, and the identified interventions in the placement setting that will encourage and support the child/youth in decreasing or eliminating the inappropriate behaviors that are interfering with success.

C.5.8 Case Management – The process by which a case plan is continuously assessed, developed, implemented, and revised accordingly toward the achievement of the goals and objectives outlined in the case plan for the child or youth and his/her family.

C.5.9 Case Management Responsibility – Responsibility for managing a case for a child or children that have been placed in out-of-home care as a result of abuse/neglect. This responsibility is assigned by CFSA.

C.5.10 Case Managing Social Worker (CMSW) – The CFSA Social Worker, or Provider Agency's Social Worker, assigned to a child or youth placed in foster care. The CMSW is responsible for the child and family assessment, development and implementation of a case plan to meet the child or youth's permanency goal. The CMSW acts as lead, and works in collaboration with identified service providers (health, mental health, education, etc.) to ensure the individual needs of the child or youth are being met through the prompt and effective delivery of services to fulfill the case plan requirements, and the comprehensive Individual Service Plan (ISP) or Individual Transitional Independent Living Plan (ITILP).

C.5.11 Case Managing Agencies – Child placing agencies that are responsible for case management and foster care services.

C.5.12 Case Plan – A written document developed by the CMSW for a child or youth that has a child abuse or neglect case with CFSA. The plan outlines the goals and objectives for the child and family, and the timeframes for achieving these goals. Case plans are reviewed periodically to assess progress and identify barriers to meeting the plan's goals and objectives. Also, for purposes of Medicaid reimbursement, the case plan must be updated whenever significant change occurs in the child or family's needs and services.

C.5.13 Case Notes – Documentation of activities that support the implementation of the Case Plan. Each engagement between the child or youth and the Case Managing Agency Social Worker is documented in the case notes and ties back to the goals in the Case Plan. The case notes should contain the how, what, why and when of the Social Worker's engagement with the child or youth. The notes should also indicate whether the child or youth refused services.

C.5.14 Children and Adolescent Mobile Psychiatric Service (CHAMPS) – A program that provides timely, home-based relief for children, youth and their families facing severe emotional disturbances. Professional clinical staff is available to provide crisis intervention to children and youth experiencing a mental health crisis in home or school. This program is funded by the DC Department of Mental Health, and administered Catholic Charities.

C.5.15 Child – An individual aged between birth and puberty. Since age varies for the onset of puberty, in this document a child is generally considered to be an individual under the age of fifteen (15).

C.5.16 Child Abuse – Physical or mental injury of a non-accidental nature, sexual abuse or sexual exploitation, or negligent treatment or maltreatment of a child caused or allowed by a person responsible for his or her welfare under circumstances which indicate that the child's health or welfare is harmed or threatened with harm.

C.5.17 Child Placing Agency – An agency licensed to provide "child placing" or "family based foster care" which includes case management and placement services.

C.5.18 Choice Provider – A mental health service provider with special designation by the DC Department of Health.

C.5.19 Concurrent Planning – The process of working towards reunification while simultaneously establishing an alternative or contingency back-up plan, with concurrent rather than sequential planning efforts in order to more quickly move children from the uncertainty of foster care to the security of a safe and stable permanent family.

C.5.20 Confidentiality – The safeguarding of information regarding children, youth and families in accordance with the Health Information Portability and Accountability Act (HIPPAA) laws, and all federal and District laws governing confidentiality.

C.5.21 Congregate Care Services – Residential care provided in group settings for children and youth placed in foster care.

C.5.22 Core Service Agency – A mental health service provider qualified by the DC Department of Mental Health that provides Medicaid-reimbursable services.

C.5.23 Developmental Disability – A chronic disability of a person five years of age or older that is attributable to a mental and/or physical impairment manifested before age 22; likely to continue indefinitely; and results in substantial functional limitations in three or more of the following areas of major life activity: self care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; economic self-sufficiency.

C.5.24 Facilitate – To coordinate actions that ensure access to the services and case activities outlined in each child or youth's ISP or ITILP. The Provider's "facilitation" ensures services are fully implemented for children and youth.

C.5.25 Family-based Foster Care – Foster care provided in a family-based foster home environment. Foster homes located in the District of Columbia are licensed in accordance with DCMR Chapter 60 regulations. Foster homes in other jurisdictions are licensed by regulations governing such care in the respective jurisdiction.

C.5.26 Family Group Conferencing (FGC) – An inclusive and informal process toward making and implementing a plan to safeguard children, youth, and adults. At the center of the planning is the "family group," which includes the immediate family as well as their relatives, friends, and other informal ties. Supporting the process are the involved community organizations and public agencies. FGC's are rooted in South Pacific (New Zealand) practices, and evident in many Native cultures.

C.5.27 Family Team Meeting (FTM) – Scheduled meeting that includes birth parents, foster families, pertinent professionals and other significant individuals in planning for the safety, care and placement of the child. Trained staff facilitates these meetings to develop or amend the case plan in all cases of initial removal of a child from his/her natural home, any changes in placement for the child, or transitions related to permanency.

C.5.28 Fictive kin – Non-blood related individuals that perform activities and hold relationships common to those of family members. These individuals are considered significant members of the child and family's life.

C.5.29 Foster care – Continuous twenty-four (24) hour care and supportive services provided for a minor in the legal custody or guardianship of CFSA while the child needs substitute care out of the natural home.

C.5.30 Guardianship – A relative adult or godparent obtains custodial rights to a child/youth through the Family Court, and a financial subsidy may or may not be involved.

C.5.31 Human Care Agreement (HCA) – A written agreement for the procurement of education or special education, health, human, or social services pursuant to DC Official Code, Section 2-303.06A, to be provided directly to individuals who are disabled, disadvantaged, displaced, elderly, indigent, mentally or physically ill, unemployed, or minors in the custody of the District of Columbia.

C.5.33 Independent Living Program (ILP) – A licensed, residential foster care program for youth aged 16 to 21 that present sufficient maturity to live without regular and continuous supervision and monitoring. Programming may be provided in a main facility or residential apartment units as determined by age and developmental functioning.

C.5.32 Individualized Education Plan (IEP) – The written plan developed for the child or youth that identifies and outlines educational needs and services, and is incorporated into the ISP/ITILP.

C.5.33 Individualized Family Service Plan (IFSP) – The written document that guides the early intervention process for children with disabilities and their families in accordance with Part C of the Individuals with Disabilities Education Act (IDEA). The plan contains information about the services necessary to facilitate a child's development and enhance the family's capacity to facilitate the child's development. Family members and service providers work as a team to plan, implement, and evaluate services tailored to the family's unique concerns, priorities, and resources.

C.5.34 Individualized Health Plan (IHP) – The written plan developed for the child or youth that identifies and outlines the health needs and service delivery, and is incorporated into the ISP/ITILP.

C.5.35 Individual Service Plan (ISP) – The written, comprehensive plan for a child or youth that specifically identifies all the goals, objectives, strategies, services, and responsible parties and resources required to address the assessed strengths and needs. The CMSW develops the plan, and leads periodic reviews that include the child or youth, and all relevant parties. The ISP encompasses a summary of the findings and recommendations of the IEP, IHP, ITP, IFSP, ITILP and Structured Decision Making Tools.

C.5.36 Individual Transitional Independent Living Plan (ITILP) – The written, comprehensive plan that specifically identifies all the goals, objectives, strategies, services and responsible parties and resources to address the assessed strengths and need areas of a CFSA child or youth. The CMSW develops the plan, and leads periodic reviews that include the child or youth, and all relevant parties. This plan has more focus on independent living skill goals and objectives than an ISP.

C.5.37 Individualized Treatment Plan (ITP) – The written plan developed for a child or youth that identifies and outlines the treatment needs, and is incorporated into the ISP/ITILP. This plan shall include the specific services needed by the child or youth to meet their treatment goals, including the scope, frequency and duration of the services needed. Documentation of the service shall include: the name of the child and Medicaid number (if available); name of Provider and professional credentials; the service provided, and the time, date, place, and length of the service; and a note describing how the services relates to the treatment goal.

C.5.38 Legal Custody – An adult obtains custodial rights of a child/youth through the Family Court, and no financial subsidy is involved.

C.5.39 Mandatory Reporter – An individual involved with children or youth as per professional role that is required to report abuse and neglect.

C.5.40 Medically fragile – Children or youth with significantly debilitating medical conditions that impair daily functioning and require close medical supervision.

C.5.41 Mental Health Service Provider – May be one of the following: a Department of Mental Health Cores Service Agency (CSA); a CFSA contracted vendor; a Crime Victims mental health provider; or a mental health provider through the Health Services for Children with Special Needs (HSCSN) network.

C.5.42 Out-of-Home Care – Synonymous term for foster care.

C.5.43 Performance-based HCA – A method of contracting for services that specifies outcome measures or other performance measures that must be met by the contracted Provider, and links reimbursement amounts, schedules of payments, and/or incentives and/or disincentives to performance, as specified in the agreement.

C.5.44 Permanency – The provision of a permanent living arrangement for a child based on the Federal Adoptions and Safe Families Act (AFSA) requirements. Also the process by which a child in CFSA foster care, and his/her family, benefits from case planning, periodic reviews, and other procedural safeguards to ensure that the child enters care only when necessary and appropriately placed, and is returned home or to a permanent living situation in a timely fashion.

C.5.45 Permanency Opportunities Project (POP) - A community-wide effort developed by CFSA in partnership with Adoptions Together to address the need for children to be provided opportunities for permanency. The purpose of POP is to achieve permanency for youth in DC foster care by removing barriers and creating opportunities.

C.5.46 Permanent or "Lifelong" Connection – An enduring connection established between the youth and at least one adult committed to a safe, stable and supportive relationship in order to provide lasting support and guidance to the youth as he/she transition from foster care to self-sufficiency. This is a permanent connection that should last beyond the youth's involvement with CFSA. The adult may or may not be a family member.

C.5.47 Post-permanency period – The period of time following achievement of the permanency goal for the child during which the CMSW with case management responsibility continues monitoring and supportive activities to ensure safety, well-being, and continued success with permanency.

C.5.48 Provider Agencies (or Providers) – Licensed, private agencies providing group or family based foster care and/or case management services as per a HCA between the Provider Agency and CFSA.

C.5.49 Quality Assurance – The process for identifying gaps in services, evaluating and tracking the completeness and accuracy of service delivery based on compliance with statutory and regulatory requirements, and examining and monitoring the performance of staff.

C.5.50 Qualified Provider – A Provider of human services that has received a HCA as per a review process of organizational qualifications to deliver services.

C.5.51 Respite Care – Short-term care provided by licensed, approved respite care providers or other licensed foster parents for the express purpose of relieving or providing rest to the primary foster parents or the child.

C.5.52 Reunification – The positive conclusion of providing care and guidance to children in CFSA custody whereby they are reunited with their family or legal guardian. The case is no longer open with the court; however, in cases where the child/youth is reunified under protective supervision of the court, monitoring of the case continues for a defined period while the child/youth remains in the home.

C.5.53 Safety – Protection from or absence of imminent danger, harm or injury.

C.5.54 Specialized Family Based Foster Care – Foster care in family based foster homes for children and youth with developmental disabilities and/or conditions of medical fragility.
Structured Decision-Making - An approach to child protective services that uses clearly defined and consistently applied decision-making criteria of screening for investigation, determining response priority, identifying immediate threatened harm, and estimating the risk of future abuse and neglect. Child and family needs and strengths are identified and considered in developing and monitoring progress toward a case plan.

C.5.55 Task Order – An order for services placed against an established human care agreement.

C.5.56 Teaming – A group of professionals representing various aspects of the child or youth's well-being interests from a health, mental health, educational, life and social skills, and permanence perspective that collaborate toward meeting the needs of the child or youth through assessment and service planning and delivery. CFSA's teaming process is a shared decision-making approach that is coordinated and primarily led by the CMSW. In most instances, it is the CMSW who leads the engagement process and the formulation of the team. There may be occasions in which another facilitator leads the team's planning efforts. In cases such as that of an older youth, or a family nearing permanency, another member of the team may naturally or voluntarily assume the role of team leader. In each of these scenarios, the CMSW retains primary responsibility for the direction and management of the case, including ensuring decisions made by the team are carried out by the responsible party.

C.5.57 Teen Parent Family Based Foster Care – Foster care in family based foster homes for pregnant and parenting teens and their dependent children.

C.5.58 Therapeutic Family Based Foster Care – Foster care in family based foster homes for children and youth that present Axis One conditions requiring more therapeutic care.

C.5.59 Traditional Family Based Foster Care – Foster care in family based foster homes for children and youth presenting emotions and behaviors typical of those having suffered abuse/neglect warranting removal from their natural home.

C.5.60 Units of Service – Term used for the purpose of billing for services delivered by a Provider to a client, in this case a child or youth placed in care by CFSA. Units defined in 15-minute increments of service or more.

C.5.61 Well Being – The healthy physical, emotional, intellectual, and spiritual development and existence of a human being.

C.5.62 Youth – An individual in age between the onset of puberty and early adulthood. Definitions vary of the specific age range that constitutes youth, but for the purposes of this document, the age range for a youth is age fifteen (15) to twenty one (21).

C.6.1 Case Management Responsibility

C.6.1.1 Once assigned by CFSA, the Provider shall retain responsibility for case management services and supports until the child's case plan goals have been met, or the child has achieved permanency through reunification, legal guardianship, or a finalized adoption.

C.6.1.2 The primary role of the CMSW is to assess the needs of the child and family, and to work towards achieving permanency for children that come into foster (or out-of-home) care, identify and coordinate all services necessary to achieve this goal, as well as ensure the safety and well being of the child during his/her foster care stay. The CMSW shall work with the child's family to address the safety and risk issues that brought the child to the attention of CFSA.

C.6.1.3 The Provider shall retain case management responsibility, during periods of temporary placement in care settings not affiliated with the Provider, until the child's case goals have been met.

C.6.1.4 The Provider shall maintain case management responsibility and supportive activities during a post-permanency period (specified in Section C.6.13) following achievement of the permanency goal.

C.6.1.5 The CMSW, in its work with assigned families, shall continuously assess the progress of each family, and immediately report to CFSA's Child Protective Services (CPS) or the appropriate local CPS for follow up, any incidents of imminent risk (need for immediate removal) to children in the home.

C.6.1.6 Case management services for non-court involved children that are not living in the home, are not included as part of the services outlined in this solicitation.

C.6.1.7 Further definition of Provider case management responsibilities may be developed during the term of HCA, that may modify portions of this role. Such changes will be established as policy or through CFSA Administrative Issuances (AI's) for family based foster care, and therefore inherent to the expectations of Case Managing Family Based Foster Care Agencies.

C.6.2 Assignment of Case Management Responsibility

C.6.2.1 CFSA shall assign case management responsibility to a Provider Agency on a rotating basis and according to the service need at the time of placement of the child, or children (in the case of a sibling group), into that Provider Agency's family based foster care network.

C.6.2.2 The Provider's CMSW shall provide assessment, case and service planning, as well as implementation of services for each child assigned to the caseload.

C.6.2.3 In addition to case and service planning activities pertinent to each child on a caseload, a Provider (referred to as "Provider A") shall be assigned primary responsibility for managing permanency and support efforts for the natural family under one or more of the following cenarios:

C.6.2.3.1 The only child in out-of-home (foster) care is placed in one of Provider A's foster homes.

C.6.2.3.2 There are children placed with multiple agencies (last resort), but Provider A's placed child (or children) has a goal of reunification.

C.6.2.3.3 The child first entering care had been placed with Provider A, and siblings subsequently entered the system and had to be placed with an alternate Provider Agency due to Provider A's inability to accommodate them with a foster home placement.

C.6.2.3.4 There are children placed with multiple agencies that all have a goal of reunification, but CFSA's Placement Services Administration has chosen to assign responsibility to Provider A.

C.6.2.4 The CMSW with primary responsibility for the family shall act as the lead author of case plan documents and court reports as it relates to permanency planning, and shall team with any other CMSWs with case management responsibility for siblings in the planning efforts and preparation of documents.

C.6.2.5 During periods in which a child may be temporarily placed with an alternate Provider (for example, a stay in a Residential Treatment Center), the Provider with case management responsibility for the child shall maintain this role in support of the child and family, and resume placement responsibility within its own foster home array, but still needs Placement Services Administration approval. The Provider's business plan should reflect consideration of this responsibility.

C.6.2.6 If in the course of working with the natural family, the CMSW determines there is an imminent risk of removal based on concerns for the safety and well-being of any children that might be residing in the natural home, the CMSW shall follow the Mandatory Reporter protocol. The CMSW shall call the CFSA Hotline, or the appropriate local CPS, to report any suspected neglect or abuse warranting further investigation, and indicate that this is a report from a Provider Agency involved with the family. CFSA shall prioritize such reports in response to the Provider's preliminary assessment.

C.6.2.7 If removal of children occurs under circumstances outlined in C.6.2.6, CFSA's Placement Administration would seek to place siblings together with the original Provider of case management services.

C.6.3 Case Managing Social Worker's (CMSW's) Role

C.6.3.1 The Provider's CMSW shall serve as the "driver" of the case plan that guides, determines and documents progress on the child and family's case as it relates to permanency; and to the safety and well-being of the child during foster care. The CMSW tracks and receives reports from all services in which the child and/or family is involved.

C.6.3.2 The CMSW's role includes continuous assessment, case and business planning, and implementation, teaming, court and other case related administrative responsibilities.

C.6.3.3 The CMSW shall employ a practice approach that incorporates the concepts and protocol outlined in CFSA's "Out-of-Home Practice Protocol".

C.6.3.4 The CMSW shall have primary responsibility for documentation of all case related activities including, but not limited to, the case plan, business plan, education plan, health plan, family business plan, case notes, and court reports.

C.6.4 Assessment

C.6.4.1 The CMSW shall implement methods of effective assessment to include:

C.6.4.1.1 Safety and risk factors in the natural home and out-of-home foster care settings from initial contact to case closure using evaluation tools such as risk assessment tools, Structured Decision Making (SDM) and family group decision conferences.

C.6.4.1.2 Strengths and needs of family and child in an effort to assist families to mobilize strengths to raise the level of family functioning.

C.6.4.1.3 Formal assessments, as needed, such as health, psychological and educational evaluations to inform case planning.

C.6.4.1.4 Any other assessment of the child's needs to assure the child's health, well being and progress towards the case plan and permanence.

C.6.5 Teaming

C.6.5.1 The CMSW shall employ a case planning approach that prioritizes "Teaming" in practice. Teaming is the foundation of the District of Columbia's child welfare case practice; and is a strategy, while led by the CMSW, that establishes opportunities for collaboration and information gathering to effectively work on behalf of the child. Team meetings occur at

major points in case planning to include the child/youth, family and service providers, foster parents and any significant individuals relevant to the child's permanency and/or well being. Teaming is further described in CFSA's "Out-of-Home Practice" Protocol.

C.6.5.2 A Family Team Meeting (FTM) will be scheduled by CFSA's CPS within 72 hours of the placement of the child that will lead to an initial Case Plan. The Provider's assigned CMSW shall convene a follow up team meeting with family members within thirty (30) days of case assignment.

C.6.6 Engagement

C.6.6.1 The CMSW shall engage, and provide supports and needed services, for the child and family to assure the conditions bringing the child into care are being resolved in such a manner as to support the achievement of the permanency goal for the child. The CMSW shall assure that the child/youth, mother, father, extended maternal and paternal family, primary caregiver, and other team members clearly understand the roles of the CPS investigator and the ongoing CMSW, legal aspects, assessment, permanency, strategies and plans. Engagement is further described in CFSA's "Out-of-Home Practice" Protocol.

C.6.6.2 The CMSW shall make attempts to re-engage with those parents that have been "absent" (every six months by federal standards), including a diligent search for family members. The CMSW shall also make efforts to engage kinship or fictive kin resources for the child.

C.6.7 Case Planning

C.6.7.1 The CMSW's case plan shall include identification of family strengths and needs (as outlined in the SDM tools); overarching goals that are specific, measurable, achievable, relevant, time sensitive as it relates to permanency; and a service plan that assesses and identifies the service needs, reports implementation of these services, and the progress being made by the child and family as per these interventions and supports, and the extent to which they are achieving the case goals.

C.6.7.2 The CMSW shall ensure that Case Notes fully document engagements with the child or youth around the goals in the Case Plan to include the how, what, why and when Case Note methodology.

C.6.7.3 The CMSW shall employ concurrent planning to support timeliness in achieving permanency goals regardless of whether the court orders a concurrent permanency goal.

C.6.7.4 The Provider's CMSW and/or Supervisor shall participate in all CFSA quality control activities pertaining to case planning, treatment, placement, permanency, and family resources, to include, at a minimum, Quality Service Reviews (QSR's), Administrative Reviews, and multi-disciplinary Individual Service Plan (ISP)/Individual Transitional Independent Living Program (ITILP) reviews.

C.6.8 Service Planning

C.6.8.1 The service plan shall reflect supports and activities to be provided to achieve the case plan. The CMSW shall take the lead in the development of the ISP that includes the following components: Behavior Management Plan (BMP), Individualized Treatment Plan (ITP),

Individualized Education Plan (IEP), or Individual Family Service Plan (IFSP) (children birth through age two), and Individualized Health Plan (IHP). The CMSW cannot take the lead in IEP planning, as this is a Local Education Agency function, but should participate fully in the process.

C.6.8.2 The CMSW and caretaker (foster parent) shall work with the child or youth to meet his/her ISP objectives by providing a structured treatment environment that assures curative care, designated treatment, appropriate service referrals and linkages, and participation in progress review and planning.

C.6.8.3 The CMSW shall convene a multi-disciplinary team for regularly scheduled Case Plan and ISP reviews for children and youth in its care that include the CMSW, foster parents, the Provider's most relevant staff managing service planning, any pertinent professionals in the assessment and/or service delivery array, the child or youth, and any pertinent family members.

C.6.8.4 The Provider shall provide CFSA with documentation on all service related developments for each child or youth placed in its care. See Section C.10.7 of this agreement for documentation requirements.

C.6.8.5 The Provider shall identify and access a wide range of community based support services for children and families who are assigned as out-of-home care cases, and that promote permanency goals and the health and well being of each child.

C.6.9 Achieving Permanence and Developing Life-Long Resources

C.6.9.1 The CMSW shall provide case management activities for the child and family to assure the conditions bringing the child into care are being resolved in such a manner as to establish and support achievement of the permanency goal for the child.

C.6.9.2 The CMSW shall actively pursue reunification as the initial goal by meeting regularly with birth parents, developing a clear plan, making timely referrals for services, and ensuring children maintain their bond through weekly visitation.

C.6.9.3 The CMSW shall seek permanent resources for the child beginning with identification of family members or fictive kin at the initial Family Team Meeting (FTM) that could serve as caretakers or significant "life-long" resources for the child, in the event the goal for reunification cannot be realized with the natural parent(s).

C.6.9.4 The CMSW shall complete social work activities from the perspective that all children and youth deserve and can achieve permanence; and fully document (in case notes) all efforts to achieve permanence through reunification, guardianship, adoption, or long-term permanent connections, regardless of age, physical, emotional, or health conditions of the child or youth in care.

C.6.9.5 The CMSW shall cultivate permanent resources in the event reunification cannot be realized with the natural parent(s). In addition to working with kin, fictive kin, the foster family, or an adoptive family, the CMSW shall cultivate relationships that may serve as "life-long" resources for the child, despite not being able to serve as a permanent placement resource. CFSA will support the permanency efforts of Provider Agencies by lending the assistance of a Permanency Specialist to collaborate with CMSWs in this endeavor.

C.6.10 Placement Stability

C.6.10.1 The CMSW shall ensure that a child or youth is placed in a foster care home environment that is safe, stable, creates a curative and nurturing environment, and supports achievement of well-being goals while the permanency goal is being pursued.

C.6.10.2 The CMSW shall be the guiding force of the service plan while the child is in placement (see Section C.6.8 for Service Planning requirements). The CMSW shall visit the child regularly in placement to ensure continued safety and well-being; and to proactively address any threats to placement stability via assessment and implementation of supports and/or interventions.

C.6.10.3 The CMSW shall engage the foster parent in progress and development of the child and communicate any training, support or other assistance the foster parent may require to sustain the stable placement of the child.

C.6.10.4 The CMSW shall lead "teaming", as necessary, to resolve significant, emerging issues, and to avoid disruption of the child's placement.

C.6.10.5 The Provider shall only make request for a change in a child's placement in accordance with those conditions outlined in the Intake and Admissions Section C.9.1.2, as per federal guidelines, and the requirements of this agreement, placement stability is a well being outcome for children and youth placed in foster care. As part of the continuous assessment and planning for each child, any placement move will be based solely on the observed, significant progress, or lack thereof, over time that warrants a planned placement change to assure the safety, progress or development of the child.

C.6.10.6 All placement changes shall have the approval signature of the Provider's Program Director with prior approval of CFSA's Placement Services Administration (including foster home changes within the same Provider Agency).

C.6.10.7 All placements, including changes of setting within the same Provider Agency, shall occur though the CFSA's Placement Services Administration.

C.6.11 Visitation

C.6.11.1 The CMSW shall ensure completion of all required visits in accordance with the AIP and Modified Scorecard requirements to include:

C.6.11.1.1 Twice monthly with CMSW and child/youth and caregiver in the placement setting.
C.6.11.1.2 Twice monthly between CMSW and birth parent(s) in cases of reunification as the goal.
C.6.11.1.3 Weekly between child/youth and birth parent(s) in cases of reunification as goal.
C.6.11.1.4 Twice monthly between the child/youth and siblings.

C.6.11.2 The CMSW shall utilize visitation to ensure safety, sustenance of important relationships, well being, and achievement of permanence in a timely manner. The team for the child or youth (as per description of team composition in Section C.6.5) shall develop a regular and frequent schedule of parent-child and child-sibling visits as part of the case plan, and coordinate implementation with the caregiver.

C.6.12 Court Activities

C.6.12.1 The CMSW shall be responsible for attending court hearings to represent the case to the court that effectively advises the court on the case plan for permanency, safety and well being as per the "teaming" that has collectively made such decisions.

C.6.12.2 The CMSW shall have a draft court report prepared and submitted to the CFSA's Assistant Attorney General (AAG) at least five (5) business days before the filing deadline. Court reports shall be timely, comprehensive, and address the following:

C.6.12.2.1 Any unresolved orders and services;

C.6.12.2.2 Engagement with the foster caregiver, service providers, school, and other family members; Summary of work that has taken place since the last review in keeping with the case plan and permanency goal that outlines reasonable efforts toward achievement of the permanency goal;

C.6.12.2.3 Update on services that advance well being for the child or youth.

C.6.12.3 Between scheduled hearings, the CMSW shall be in regular contact with all team members, specifically the foster parent, birth family members, and any other relatives, service providers, school and the AAG. The CMSW shall notify birth parents and resource family members of all hearings, and encourage them to participate in court hearings.

C.6.12.4 The CMSW shall prepare any interim reports needed as a result of an emergency, change in placement, abscondance, or arrest; when the Agency receives a new allegation of abuse or neglect; or any other event the court may need to know about before the next hearing. The CMSW should consult with the AAG to determine whether an emergency hearing is warranted.

C.6.12.5 If the CMSW is proactively addressing the needs of the case, the Superior Court should not be issuing any court orders required of the Agency. In the event of a court order, the CMSW shall ensure that the team implements these orders and accounts for their status. If the CMSW encounters difficulties implementing the order, the CMSW shall consult with his/her supervisor and the AAG immediately.

C.6.12.6 If the CMSW wishes to modify an order, contact shall be made with the AAG to determine whether or not the Agency can seek modification, additional time to comply, or request that the order be vacated.

C.6.12.7 The CMSW may need to testify at various evidentiary hearings throughout the life of a court case. The CMSW shall be fully prepared with strong documentation that has been updated regularly in FACES.

C.6.13 Post-Permanency Period Support and Closure of Case Management Responsibility

C.6.13.1 Once the permanency goal has been achieved for a child, the CMSW may shift the case into a post-permanency period during which time the CMSW shall continue to monitor and provide supportive activities to the child and any individuals pertinent to the success of the permanency plan. See Sections C.6.3 – C.6.12 for specifics of case management activities.

C.6.13.2 In cases of reunification, the Provider shall continue to monitor the safety of the child to ensure the child is stable in the home for a six month period during which post-permanency support shall be provided to the child and family.

C.6.13.3 In cases of adoption, the case management responsibilities extend through finalization of the adoption, and the referral and connection of the adoptive family with the Post Permanency Center for post-adoption services.

C.6.13.4 When a youth exits the system to live independently, the case management responsibilities will include the establishment of a "lifelong connection", and a comprehensive plan that includes work, housing, education, and other necessary life skills. The Provider shall continue post-permanency services for six months to include monitoring for safety and well being, and supportive activities that ensure the success of the permanency plan.

C.6.13.5 In situations warranting an extended post-permanency period (i.e., the period of time needed to stabilize the child's return home takes longer than six months), the Provider may negotiate an extension of case management responsibility for which CFSA will continue standard reimbursement.

C.6.14 Case Management Transfer

C.6.14.1 CFSA expects the Provider to maintain case management responsibility until permanency has been achieved for the child, or children, from a particular family. If extenuating circumstances (as defined in this section) require a transfer of case management responsibility, a transfer staffing must take place before the case is officially transferred.

C.6.14.2 The Provider shall adhere to CFSA policy on case transfers and staffing for transfer of cases from CFSA to a Provider, or from one Provider to another. The required tasks for an initial case transfer may be accomplished within a FTM; however, a supplemental meeting specifically focused on the administrative tasks associated with case transfer is often needed.

C.6.14.3 The Social Worker initiating a transfer must complete all required FACES fields of data prior to the Transfer Staffing, as well as the electronic transfer. Case plans must be completed if due within thirty (30) days of a transfer. While a child may be placed with the receiving Agency, the Social Worker initiating transfer is responsible for entering data into FACES until the case has been transferred electronically to the receiving Agency.

C.6.14.4 In the event that a child's placement has been changed from the Provider for which case management responsibility had been assigned for this child, and there are other children in foster care being case managed elsewhere, the Provider may make a request of CFSA for a transfer of case management responsibility.

C.6.14.5 If the Provider achieves permanence for the child in placement, the Provider may request transfer of case management responsibility for any children that may be in the natural home, but, are not in need of removal for out-of-home services. If the family presents the need for continued supports, and the children in the home are not at risk of abuse or neglect, the Provider shall ensure that the family is referred and receiving necessary specialized services from a community based service agency such as the Healthy Families/Thriving Communities Collaborative.

C.7 CHILD WELL-BEING

C.7.1 The Provider shall meet the needs of the child as designed in the case plan via a collaborative effort between CMSW, service providers, family members, and Foster Parent(s). In the design of the case plan, the CMSW shall include a service plan with components for the following:

C.7.1.1 Daily routine and schedule;
C.7.1.2 Behavior management;
C.7.1.3 Mental health services and supports, such as individual and group counseling, crisis intervention, medication management;
C.7.1.4 Health care services and coordination;
C.7.1.5 Educational and vocational support services;
C.7.1.6 Therapeutic recreation;
C.7.1.7 Life and social skills development;

C.7.1.1 Daily Routine and Schedule

C.7.1.1.1 The Provider shall establish and ensure foster parents implement a structured routine and schedule of events and activities that promote healthy development and improve social and behavioral functioning. The routine and schedule should incorporate all elements outlined in this "Child Well-Being" section. Children or youth should have minimal, if any, periods of unstructured time in their daily routine.

C.7.1.2 Behavior Management Policy

C.7.1.2.1 The Provider shall develop and implement a comprehensive behavior management policy and protocol for all children and youth that fully describes expectations of foster parents in managing children in their licensed homes.

C.7.1.2.2 The Provider shall include goals and objectives in the plan that address any positive strengths or maladaptive behaviors that may hinder the individual from functioning well in the home, school, with family, or in the community. The Provider shall review and update the plan periodically in the context of a child's service plan and/or treatment plan reviews.

C.7.1.2.3 The Provider shall employ behavior management techniques to assist the child with behavior problems in understanding the consequences of inappropriate behavior and minimize the negative side effects that interfere with the child's personal development and community integration. Behavior management training shall be designed to develop, restore, manage and maintain the child's mental or emotional growth and teach and reinforce appropriate behaviors. Any child who requires a combined behavioral management, medical and/or mental health plan should be approved by the Provider's Director of Clinical Services in consultation with CFSA's OCP.

C.7.1.2.4 The Provider shall administer a monetary allowance system for children and youth placed in care, as is developmentally appropriate. The Provider shall describe the system to include the specifics of allowance disbursement and fostering of banking/savings skills. The Provider should outline the costs associated with allowances in its budget submission. All costs and policies shall be aligned with CFSA related protocols.

C.7.1.3 Mental Health Services and Supports

C.7.1.3.1 The CMSW, in consultation with CFSA's OCP (OCP), shall address the mental health needs and plans for each child in collaboration with the DC Department of Mental Health via a network of Choice Providers or Core Service Agencies. The Provider shall assist in the facilitation of assessment and provision of the mental health services as outlined in a child or youth's ITP. The ITP is a component incorporated into the Individualized Service Plan (ISP) for the child or youth.

C.7.1.3.2 The Provider, as part of the multi-disciplinary team, shall participate in the development and implementation of an ITP that identifies and outlines the services needed for children or youth placed in care. The ITP shall be based on the information derived from the evaluation and assessment conducted by the Mental Health Service Provider; shall include present level of functioning in the domains mentioned above; shall maintain treatment objectives in measurable terms; shall indicate the specific services and supports necessary to meet the unique needs of the child or youth; and shall include names and titles of persons responsible for implementing the ITP. The ITP must be signed by an appropriate clinician such as a Psychiatrist, Psychologist, licensed professional counselor; or, a Licensed Independent Clinical Social Worker (LICSW) or Licensed Graduate Social Worker (LGSW), under the supervision of a Board certified Psychiatrist or Psychologist.

C.7.1.3.3 The Provider shall ensure transportation to and documentation of any individual or group mental health counseling or psychotherapy services obtained, in accordance with a child or youth's ITP, that includes face-to-face intervention by an appropriate clinician such as a Psychiatrist, Psychologist, licensed professional counselor, LICSW, LGSW, under the supervision of a Board Certified Psychiatrist or Psychologist.

C.7.1.3.4 The Provider shall ensure children and youth have access to individual and group counseling (no more than 8 children or adolescents to 1 professional) that is psycho-educational in nature to address, but not be limited to, the following topics:

C.7.1.3.4.A Grief, loss and separation counseling - to assist the child with abnormal or complicated grief, loss and separation reactions to help separation, prolonged grief, and/or address masked somatic or behavioral symptoms as a result of the grief response.

C.7.1.3.4.B Anger management techniques and training – to assist in managing "anger", which is a normal, natural reaction to situations that cause disappointment, hurt, frustration, sadness, and other negative emotions

C.7.1.3.5 The Provider shall have staff trained in mental health crisis intervention to support foster parents when children or youth may have episodes warranting clinical and/or behavioral intervention. If the Provider's staff is unable to stabilize the child or youth, the Provider may utilize the Children & Adolescent Mobile Psychiatric Service (CHAMPS) for the provision of timely, home-based relief for children and adolescents in crisis. This service provides in-home assistance when appropriate, and assesses whether a child's behavior poses a danger, requiring possible psychiatric inpatient hospitalization. The Provider shall notify CFSA's OCP of mental health crises for consultation and further support.

C.7.1.3.6 The Provider shall have access to a Psychologist or Psychiatrist for clinical and medication consultation. In collaboration with the Behavioral Specialists they shall provide supportive clinical assistance to the CMSW and foster parents to review symptomotology of the illness, discuss benefits and side effects of medication, and to assess medication administration.

C.7.1.3.7 The Provider shall facilitate access, service linkages and monitoring of these services to assist and enable the child or youth to receive services authorized in the ITP.

C.7.1.4 Health Care Services

C.7.1.4.1 The CMSW shall plan, facilitate, and coordinate all preventive, routine, and emergency health care needs for each child or youth in coordination with the child or youth's IHP and CFSA's Clinical and Health Services Administration in the OCP. All services will be initiated with DC Medicaid Providers to the extent possible, and follow the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) requirements issued from the Department of Health Care Finance and the American Academy of Pediatrics.

C.7.1.4.2 The Provider shall collaborate with CFSA's Clinical and Health Services Administration to ensure an Individualized Health Plan (IHP) is developed and included in the child or

youth's Individual Service Plan. The IHP shall fully identify health needs, and describe the services required to meet these needs.

C.7.1.4.3 The CMSW shall follow CFSA's referral process to access medical services and for communicating appointment outcome information to CFSA.

C.7.1.4.4 The Provider shall follow CFSA's guidance for securing, in a timely manner, all medically recommended health and therapeutic services including, but not limited to, counseling, behavior management, medication management, physical, occupational, and/or speech therapy, glasses, hearing aids, prosthetic devices, and corrective physical and dental devices.

C.7.1.4.5 The CMSW and the OCP shall facilitate the provision of physician-prescribed in-home nursing and/or assist with the acquisition of any other specialized health services in accordance with the case plan and Individualized Health Plan and sanctioned by CFSA's Clinical and Health Services Administration.

C.7.1.4.6 The CMSW shall refer all pregnant youth and other special health populations to the OCP and Health Services Administration. The OCP will coordinate, with the CMSW, appropriate community-based prenatal care through a Medicaid Obstetric and Gynecological Provider for all youth in need of and seeking such services.

C.7.1.4.7 The Provider shall ensure an emergency protocol that establishes which professional staff facilitate transport and accompany the child or youth to the nearest medical facility, as well as provide the facility with Medicaid information. The Provider or CFSA staff shall remain with the child for the duration of any emergency treatment. The Provider shall notify the CMSW as soon as possible. The Provider shall notify the OCP's Clinical and Health Services Administration through the 24 hour on-call phone: 202-498-8456 or through the CFSA Hotline. The Provider shall not consent to treatment. In a true life-threatening emergency, treatment will be initiated by the emergency room staff.

C.7.1.4.8 The Provider shall include in its training plan a module that prepares foster parents on health care topics to include, among others, the following: Early Periodic Screening, Diagnosis, and Testing (EPSDT), HIV/AIDS, communicable diseases, universal precautions, nutrition, diabetes, dental/oral care, asthma, and well child care.

C.7.1.4.9 The Provider shall follow CFSA's guidelines for youth affected by HIV and AIDS.

C.7.1.4.10 The Provider shall ensure on-call availability of a physician for emergent and urgent services and consultations.

C.7.1.5 Educational and Vocational Services

C.7.1.5.1 The Provider shall be responsible for meeting the educational and vocational needs of all children/youth placed in its care. The Provider shall arrange for and ensure that each school-aged resident attends an educational or vocational program in accordance with all applicable federal, state and local laws and the child/youth's Individual Service Plan (ISP) and any

Individualized Education Plan (IEP). To the extent possible, the Provider shall ensure that all children remain in their school of origin when it is in his/her best interest to do so, as required by federal and local laws. The Provider should consult with the CFSA Education Resource Specialists in the OCP to assist with best interest planning and decision-making, and for any educational supports and guidance needed.

C.7.1.5.2 The Provider shall have primary responsibility for enrolling and transporting all school-age children and youth to educational, extra-curricular, vocational and/or mentoring activities; unless otherwise provided by the school district, another community-based service provider, or arranged by CFSA, to address a specialized educational need as defined in the service plan.

C.7.1.5.3 The Provider shall comply with CFSA policy regarding educational planning for children/youth in care such as educational assessment and out-of-state school enrollment and tuition. Specifically, the Provider shall comply with CFSA's Administrative Issuance (CFSA-09-21) regarding Completion of Education Assessments. The assigned CMSW shall complete an Education Assessment form for every school-aged child/youth aged 5-18 years of age within 30 days of placement in foster care to be reviewed and approved by the assigned Supervisory Social Worker. This assessment will assist Social Workers in identifying academic strengths and deficiencies of the child or youth. Educational information must be entered on the Client Education Screen in FACES, as well as on the Educational Assessment form to be placed in Section D of the case record. Educational information should be updated in FACES at critical points such as school placement change, the end of each marking period, any new or updated IEP, and whenever the Education Assessment is updated.

C.7.1.5.4 The Provider shall engage the child or youth, his/her birth parent, foster or other educational decision-maker in all education planning and decision-making activities. The Provider may consult with a CFSA Education Resource Specialist if a child/youth does not have a parent or educational decision-maker to act on his/her behalf.

C.7.1.5.5 The Provider shall be a member of the child's educational team and convene and/or participate in teaming meetings with the child's teacher and other school personnel, the child/youth and his/her parent, foster parent or other educational decision-maker.

C.7.1.5.6 The Provider shall ensure that youth who are no longer required to attend school under the District of Columbia's or local jurisdiction's Compulsory Education Law receive directly, or are appropriately linked to, continuing education or other resources and services aimed at preparing the young person for economic independence, such as a vocational training program.

C.7.1.5.7 The Provider shall maintain the children or youth's educational records; including, but not limited to, report cards, educational and standardized testing and Individualized Family Service Plans (IFSP) or Individualized Education Plans (IEP's). The Provider shall make copies of all educational information available to CFSA on a monthly basis; or more often if the Provider receives pertinent information between monthly reviews.

C.7.1.5.8 The Provider shall ensure that all children and youth in need of Special Education receive assessment by the assigned school, or another authorized Special Education evaluator approved by the District of Columbia Public Schools (DCPS). In a timely fashion, the Provider shall ensure participation in all meetings held at the child or youth's local school in order to develop and/or enhance the IEP. The foster parent, or natural parent, as appropriate, shall be involved in educational decision-making.

C.7.1.5.9 The Provider shall comply with education policies set forth by DCPS and CFSA regarding the provision of special education services and other guidance on a variety of education-related topics. The CFSA Education Resource Specialist is available for consultation and assistance in this area.

C.7.1.5.10 The Provider shall ensure foster parents facilitate educational enrichment programs and activities for children and youth.

C.7.1.5.11 The Provider shall identify staff oversight and responsibility for educational planning and services (e.g., attendance at school conferences, provision of school supplies, assistance with homework, and routine contact with teachers) for children and youth placed in care. The Provider's business plan shall also include description of the educational equipment provided to youth to assist and enrich educational endeavors such as provision of computers, adequate study areas, in-home tutoring (paid or non-paid), and other assistance.

C.7.1.5.12 The Provider shall facilitate tutoring, mentoring, and other advocacy and supportive services on-site, via the school, community-based providers, or via CFSA's OCP. The Provider shall work to develop innovative provision of tutoring and mentoring services that are community-based, linked to professional groups, and/or are on a volunteer basis. The Provider shall document the provision and quality of the service.

C.7.1.5.13 The Provider shall ensure children and youth presenting any educational limitations, and or meeting criteria listed below, receive tutorial or other services to improve academic performance:

C.7.1.5.13.A Two or more grade levels behind age-appropriate academic performance;
C.7.1.5.13.B Reporting grades of D's or F's;
C.7.1.5.13.C Services recommended by IEP;
C.7.1.5.13.D Services recommended by school;
C.7.1.5.13.E Services recommended by a psychological evaluation, or;
C.7.1.5.13.F Services recommended by the ISP.

C.7.1.5.14 The Provider shall inform and document for CFSA all pertinent educational information for the purposes of data collection, monitoring, and inclusion in case records and pertinent education and service plans.

C.7.1.5.15 The Provider shall link youth to vocational services as per any service objectives set forth in the child or youth's service plan. These services shall include vocational assessment and training programs and linkage to the CFSA Office of Youth Empowerment (OYE).

C.7.1.6 Therapeutic Recreation

C.7.1.6.1 The Provider shall ensure foster parents facilitate recreational programming for children and youth that includes positive, pro-social recreational activities that reduce the risk of engaging in antisocial behaviors, and serves as a protective factor as they permanently transition from foster care to the community.

C.7.1.6.2 Foster parents shall endeavor to access recreational activities that spark the child or youth's interest, enhance self-confidence, nurture the development of hobbies, and may serve as a long-term activity. Participation in music, arts and sports is encouraged.

C.7.1.7 Life and Social Skills Training and Development

C.7.1.7.1 The Provider shall ensure that children and youth are adequately prepared by foster parents, and/or the Provider Agency, in life and social skills, and related development activities. The Provider should reference 29 DCMR Chapter 62 Section 6270 for a comprehensive listing of curriculum and program topics. The goal should be for development of these skills within the youth's family based foster care setting, and not via a transfer to a congregate care setting to achieve independent living goals.

C.7.1.7.2 The Provider shall facilitate group and individualized life skills sessions as part of its programming. The prospective Provider shall submit an overview of the curriculum, training and assessment as part of its business plan.

C.7.1.7.3 The Provider shall facilitate employment assistance and job coaching for youth.

C.7.1.7.4 The Provider shall assure that all youth have access to life skill development and career opportunities well in advance of transition to adulthood and/or independence.

C.8 FOSTER HOMES: RECRUITMENT, LICENSING, TRAINING AND SUPPORT

C.8.1 Recruitment of Foster Homes

C.8.1.1 The Provider shall actively recruit a pool of diverse and stable foster homes within the District of Columbia (DC) or in neighboring jurisdictions within 50 miles of the DC border.

C.8.1.2 The Provider shall collaborate with CFSA in any joint recruitment efforts of foster and adoptive parents toward the development of a District-wide recruitment strategy.

C.8.1.3 The Provider shall recruit and retain a full array of foster homes able to accommodate a wide range of ages, ethnic groups, and emotional and behavioral functioning of children and youth. The care and service needs of some children and youth may shift in depth throughout the term of placement, based on the child's growth and development. A comprehensive, diverse, well trained foster parent pool is essential to assure the required nurture and care of all cases managed by the Provider Agency.

C.8.1.4 The Provider of foster care to CFSA children or youth placed outside the District of Columbia, shall ensure children or youth are able to maintain relationships with their biological parents, extended families, friends, schools, place of worship, and other connections in their communities of origin.

C.8.1.5 The Provider shall recruit potential foster and adoptive parents that express an interest and commitment to the care of abused and neglected children, the willingness to work with birth families, and a demonstrated capacity to meet the permanency needs of the children and youth in their care.

C.8.1.6 The Provider shall have foster homes able to accommodate children 0 to 21 years of age, children and youth with special needs, sibling groups, and children and youth that are lesbian, gay, bisexual or transgendered.

C.8.1.7 The Provider shall implement an annual recruitment plan to assure a continuous pool of diverse and well trained foster parents.

C.8.2 Foster Home Licensing

C.8.2.1 The Provider shall assure that children are only placed in licensed, trained, foster homes at the designated capacity.

C.8.2.2 The Provider shall ensure that all foster homes are fully licensed in accordance with the regulations governing foster care in the jurisdiction in which they are located and serve children and youth. The Provider shall adhere to any regulations governing the care of Traditional, Therapeutic or Specialized Family Based Foster Care populations in the respective licensing jurisdiction.

C.8.2.3 The Provider of DC-based services shall ensure all DC foster homes are licensed in accordance with Title 29 DCMR Chapter 60. CFSA is the licensing entity for foster homes located in the District of Columbia.

C.8.2.4 The Provider shall ensure that foster home licensing is renewed as per the regulations. In the District of Columbia, the Provider shall ensure this re-evaluation and license renewal takes place every (2) years to determine the continued ability of each foster family/home to meet the requirements.

C.8.2.5 Providers in surrounding jurisdictions shall conduct a re-evaluation and renewal process according to regulations in the licensing jurisdiction, but at a minimum of every two (2) years.

C.8.2.6 The licensing and training of recruited foster and adoptive parents shall be completed within (120) days.

C.8.2.7 As part of the home study process, the Provider shall ensure that each applicant and any other person eighteen (18) or older residing in the home comply with the requirements for a

Criminal Records Check. A criminal records check shall be performed once every two (2) years as part of the re-evaluation and license renewal process.

C.8.2.8 The Provider shall ensure that a Child Protection Register Check be performed on any household member eighteen (18) years or older once every year.

C.8.2.9 The Provider shall report to the CFSA Hotline any and all suspicions of abuse or neglect perpetrated by foster parents. Children may be removed from the home during this period. If substantiated, the license will be immediately terminated.

C.8.3 Foster Parent Training

C.8.3.1 The Provider shall prepare foster and/or adoptive parents to meet the foster and/or adoptive care needs of the children served by its agency.

C.8.3.2 The Provider shall prepare and require foster parents to accept children and youth as they present a need for placement on a twenty-four (24) hour a day, seven day a week basis in accordance with parameters set forth by licensing regulations and the task order agreement for capacity, age range, and gender. These foster parents shall be prepared to accommodate the placement needs of children and youth, and minimize any use of "emergency homes" that will require a subsequent placement change.

C.8.3.3 The Provider shall assist and require foster parents to have a pre-approved back-up child care plan to accommodate readiness for 24-hour placement requirements.

C.8.3.4 The Provider shall develop a system by which to provide respite care for foster parents in situations in which the foster parent needs a respite period from the care of children or youth. This respite period shall not last longer than ten (10) days annually. If additional time is requested, cases will be reviewed by CFSA on a case by case basis.

C.8.3.5 The Provider shall support foster and/or adoptive parents in securing required licensure of homes.

C.8.3.6 The Provider shall ensure that foster parents receive training that includes, at a minimum, 30 hours of pre-service training; and subsequently, 15 hours of annual in-service training. The Provider shall include in its business plan the specifics of this training, and the model to be used. CFSA requires the use of nationally recognized training models. The Provider shall also include training on behavior management protocol to ensure appropriate methods of discipline are being employed by foster parents.

C.8.3.7 The Provider shall detail the additional training that will be provided to foster and adoptive parents that provide care to parenting teens and their children; Therapeutic and Specialized Care populations; and gay, lesbian, bisexual and transgendered children/youth.

C.8.3.8 The Provider shall assure specialized training that prepares foster parents for the needs of youth preparing for adulthood.

C.8.3.9 The Provider shall only make foster homes eligible for placement of children/youth after licensing and pre-service training, including any specialized training needed.

C.8.4 Foster Parent Supports

C.8.4.1 The Provider shall support foster parents in the provision of quality care to children and youth that ensures a curative environment that is safe, nurturing, and well-equipped to facilitate services needed to attain the child's goals and objectives.

C.8.4.2 The Provider shall assess the needs of foster parents to sustain placement of the child in the home, and devise a support system that is responsive to these needs. This system shall include home visits, telephone contact, specialized training or other in-home supports as needed. The business plan shall provide an overview of this support system, and details regarding the frequency and manner by which the Provider will determine and implement this support.

C.8.4.3 The Provider's foster parents shall have the capacity to manage and improve emotional and behavioral functioning of children and youth to enable progress toward his or her goals, especially according to those target populations identified in the Provider's business plan. The Provider shall support foster parents in serving children and youth presenting challenging behaviors and emotional crises, and shall utilize staff to assist and/or intervene in the home.

C.8.4.4 The Provider shall establish a problem solving system that addresses issues and challenges brought to the attention of the Provider by and about foster parents. This system should include strategies such as foster parent support groups, an Ombudsman, and/or appeal process.

C.9 FOSTER HOME CARE REQUIREMENTS

C.9.1 Intake and Admission

C.9.1.1 The Provider shall have a clear protocol to admit children and youth into its program on a 24-hour-a day, 7 day-a-week basis, for each day of the year, including holidays.

C.9.1.2 CFSA's Placement Administration has sole authority for making placement referrals that includes placements within the Provider's own placement network. The Provider shall accept all children and youth referred by the Placement Administration according to the target population, programs and capacity for which the Provider is contracted by CFSA.

C.9.1.3 The Provider shall establish policies and protocols for admission and intake that include submission of accurate and complete ICPC packets to CFSA's ICPC Office prior to, or within 48 hours or 2 business days of making or changing a placement, for any child who will be placed outside the District of Columbia.

C.9.1.4 The Provider shall ensure CFSA's Placement Services Administration has 24 hour access to the staff person responsible for intake and placement, and has authority to make placement decisions on a daily basis, including weekends.

C.9.1.5 The Provider shall ensure that CFSA is provided with daily census information that is accessible and any vacancies among its licensed foster homes Monday through Friday. If children are placed in one or more of its foster homes during the weekend, the Provider shall ensure that CFSA's placement staff is aware of the change in its census and available vacancies on the following Monday.

C.9.1.6 On a monthly basis, the Provider shall report to the COTR the number of vacancies and contracted vacancies for whom there are available slots, the licensed capacity of its vacant homes, and the names and dates of placement for each child placed in the program.

C.9.1.7 The Provider shall only discharge children and youth from a program as part of a planned change as per the case plan and one or more of the following circumstances. A formal conference must take place in coordination with the CMSW and the CFSA's Placement Services Administration:

C.9.1.7.1 The child or youth has progressed in functioning and/or development, and is ready for a less restrictive level of care;
C.9.1.7.2 The child or youth is in need of a more intensive, therapeutic program based on the child's functioning, the CMSW's assessment, and the Program Director's approval;
C.9.1.7.3 The child or youth is to be reunified with family or relatives;
C.9.1.7.4 The child or youth is to be adopted;
C.9.1.7.5 The child or youth has adequately met his/her independent living goals and is ready to leave foster care.

A formal teaming conference must take place among representatives from the Provider Agency (to include the CMSW), the CFSA OCP, and the CFSA Placement Services Administration.

C.9.1.8 If the Provider is requesting a placement shift to a more intensive, therapeutic program, the child or youth must meet the established criteria for therapeutic placement that includes, among other criteria, one or more DSM IV diagnoses, at least one of which is an Axis 1 diagnosis (excluding adjustment disorder). The Provider shall also produce documentation to CFSA of all progress notes, behavior management techniques employed by the program, crisis intervention and support services applied, and any relevant documents from mental health professionals. The CFSA Placement Administration will make the determination as to the need for therapeutic care.

C.9.2 Foster Home Care

C.9.2.1 The Provider shall ensure that foster homes provide the basic services outlined in 29 DCMR Chapter 60, or the respective licensing guidelines for the jurisdiction in which services are provided. The Provider shall ensure foster care fulfills the requirements outlined in this scope of work.

C.9.2.2 The Provider shall ensure coordination of care and support services between the assigned CMSW and foster parents for children and youth placed in its care. The elements of well-

being outlined in Section C.7 serve as a road map for meeting the child's needs for positive physical, social and emotional development.

C.9.2.3 The Provider shall ensure that foster parents support the goals and objectives of the case and service plan. Foster parents shall have primary responsibility for implementing daily structured programming, behavior management, and any transportation to required appointments. In some cases, the CMSW may be involved in transportation to service appointments or visits. The Provider shall ensure that coordination fully supports completion of visits and appointments.

C.9.2.4 The Provider shall establish and maintain a system of monitoring and evaluating the quality of care provided by its foster homes. The Provider shall ensure foster home capacity for provision of a safe and nurturing environment, and for meeting the well-being needs of children and youth.

C.9.3 Types of Foster Care and Specific Requirements

C.9.3.1 Traditional Family Based Foster Care

C.9.3.1.1 The Provider of Traditional Family Based Foster Care shall ensure that foster parents are adequately prepared to care for children and youth with emotional and behavioral conditions that are typical of those having experienced abuse and neglect, but do not present an Axis 1 diagnosis.

C.9.3.1.2 The Provider shall comply with the case management and placement parameters outlined below as per the Amended Implementation Plan (AIP), and any more stringent regulatory guidelines set forth in the jurisdiction in which foster care is being provided.

C.9.3.1.2.1 Case management maximum of fifteen (15) per CMSW.

C.9.3.1.2.2 Placement of no more than three (3) foster children in a two-parent foster home at any one time;

C.9.3.1.2.3 No more than six (6) children living in a two-parent foster home, to include the family's natural children in the count;

C.9.3.1.2.4 Placement of no more than three (3) children under the age of six (6) in a two-parent foster home;

C.9.3.1.2.5 Placement of no more than two (2) children a single parent foster home, for a total of no more than three including parent's natural children.

C.9.3.1.3 The Provider may only deviate from these parameters with written approval from CFSA's Contract Monitoring and Performance Improvement Administration (CMPIA).

C.9.3.1.4 The Provider shall ensure the capacity of foster homes within its array to welcome and accommodate those children and youth that are lesbian, gay, bisexual or transgendered.

C.9.3.2 Teen Parent Family Based Foster Care

C.9.3.2.1 The Provider shall include foster parents in its foster home array that are willing to accept placement of pregnant and/or teen parents with children.

C.9.3.2.2 The Provider shall endeavor to sustain a child or youth's placement with her existing foster family in the event she becomes pregnant by bolstering supportive services to stabilize the placement.

C.9.3.2.3 The Provider shall secure high quality, community-based prenatal and postnatal counseling, other reproductive health services, and adoption services, if desired, for pregnant teens and teen parents.

C.9.3.2.4 The Provider shall include the following as part of its service delivery to pregnant and parenting teens:

C.9.3.2.4.1 Placement of parent and child in the same foster home;

C.9.3.2.4.2 Modeling and instruction on appropriate parenting skills and techniques;

C.9.3.2.4.3 Training in the stages of child development, age appropriate expectations of dependent children, and age appropriate behavior modification and discipline techniques;

C.9.3.2.4.4 Instruction in appropriate child care, including time management, food preparation, and proper nutrition;

C.9.3.2.4.5 Instruction in accessing and utilizing community resources to support the youth and their children in growth and development, e.g., medical services, child care and educational services;

C.9.3.2.4.6 Appropriate involvement of the non-custodial parent in the child's life;

C.9.3.2.4.7 Supporting for the teen parent in achievement of educational/vocational goals; and,

C.9.3.2.4.8 Preparation for independent living that is comparable to services available to non-parenting youth.

C.9.3.2.5 The Provider shall adhere to case management and placement parameters set forth for Traditional populations, and take dependent children into consideration.

C.9.3.2.6 The CMSW shall refer all pregnant youth to the Office of Clinical Practice's (OCP), Health Services Administrations. The OCP will coordinate, with the CMSW, appropriate

community-based prenatal care through a Medicaid Obstetric and Gynecological Provider for all youth in need of and seeking such services.

C.9.3.2.7 The Provider shall secure high quality, community-based prenatal and postnatal counseling, other reproductive health services, and adoption services, if desired, for pregnant teens and teen parents.

C.9.3.3 Therapeutic Family Based Foster Care

C.9.3.3.1 The Provider of Therapeutic Family Based Foster Care shall ensure that CMSWs and foster parents are adequately prepared to care for this population of children and youth that present more challenging emotional and behavioral conditions common of an Axis 1 diagnosis (See Target Populations Section C.4).

C.9.3.3.2 The Provider shall facilitate training to CMSWs and foster parents specific to case management and care of this population that exceeds the minimum training requirements outlined for Traditional Family Based Foster Care. The business plan shall include details of the training plan, topics, and credentialed trainers specific to caring for children and youth suffering from Axis I diagnoses.

C.9.3.3.3 The Provider shall include in its staffing array a Director of Social Work and Clinical Services that provides guidance and oversight for case management and care of children and youth with mental health and behavioral challenges. This staff member shall be credentialed as a Licensed Social Worker, and have expertise and experience in clinical and behavioral interventions for children and youth with Axis I diagnoses (see Section H for more details on staffing array).

C.9.3.3.4 The Provider shall include in its staffing array a Behavioral Specialist(s) that can lend guidance and supportive assistance to CMSWs and foster parents on behavior management and intervention strategies. This staff shall be available for deployment to foster homes as the need may arise. The Behavior Specialist(s) shall be supervised by the Director of Social Work and Clinical Services.

C.9.3.3.5 The Provider shall ensure that the following case management and placement parameters are adhered to when accommodating children and youth in Therapeutic Family Based Foster Care:

C.9.3.3.5.1 Case management maximum of ten (10) cases per CMSW.

C.9.3.3.5.2 Placement of no more than two (2) Therapeutic foster children in a two-parent Therapeutic foster home, and no more than four (4) children to include parent's natural children.

C.9.3.3.5.3 Placement of no more than one (1) Therapeutic child in a single parent home, and no more than three (3) children in the home to include natural parent's own children.

C.9.3.3.6 The Provider may only deviate from these parameters with written approval from the

CFSA Placement Administration and HCA Monitoring and Performance Improvement Administration.

C.9.3.4 Specialized Family Based Foster Care

C.9.3.4.1 The Provider of Specialized Family Based Foster Care shall ensure that CMSWs and foster parents are adequately prepared to case manage and care for this population of children and youth that present conditions of developmental disabilities and/or medical fragility.

C.9.3.4.2 The Provider shall facilitate training to CMSWs and foster parents specific to case management and care of this population that exceeds the minimum training requirements outlined for Traditional Family Based Foster Care. The business plan shall include details of the training plan, topics, and credentialed trainers specific to caring for children and youth with development disabilities and/or medically fragile conditions.

C.9.3.4.3 The Provider shall include in its staffing array a Director of Social Work and Clinical Services that provides guidance and oversight for case management and care of children and youth with developmental disabilities. This staff member shall be credentialed as a Licensed Social Worker, and specialization in children and youth with developmental disabilities. Staff expertise required may be provided by an alternate position with a Masters or Ph.D in Education or Psychology with specialization serving this population (see Section H for more details on staffing array).

C.9.3.4.4 The Provider shall include in its staffing array a Specialist(s) that can lend guidance and supportive assistance to CMSWs and foster parents on care issues related to children and youth with developmental disabilities. This staff shall be available for deployment to foster homes as the need may arise.

C.9.3.4.5 The Provider shall include in its staffing array a Supervisor dedicated to the oversight of health care needs and services for medically fragile children and youth placed in these homes. This staff member shall have credentialing and expertise in health care management and service delivery specific to medically fragile conditions.

C.9.3.4.6 The Provider shall staff home health aides dedicated to the care and delivery of health services for children and youth with medically fragile conditions. This staff person shall visit the foster home to work with foster parents on developing a safe environment tailored and equipped to meet the needs of each child's condition. This staff person shall support the CMSW by working with the OCP to develop the Individualized Health Plan (IHP), and shall monitor the home on a continual basis.

C.9.3.4.7 The Provider shall ensure that foster homes providing Specialized Care for children and youth with medically fragile conditions are fully equipped with any and all medical equipment and/or in-home nursing assistance as specified in the child or youth's individualized health plan (IHP).

C.9.3.4.8 The Provider shall adhere to the case management and placement parameters outlined for Therapeutic Care in Section C.9.3.3

C.10 GENERAL REQUIREMENTS

C.10.1 Service Integration/Linkage

C.10.1.1 The Provider shall develop formal relationships and agreements with other CFSA service providers, District agencies serving children, youth and families, and community-based organizations. The services shall be appropriate to the age, gender, sexual orientation, cultural heritage, developmental and functional level, as well as the learning ability of each youth. The Provider shall demonstrate evidence of such a service network via sub-contracts, formal service agreements, and/or memoranda of understanding among members of the service network.

C.10.2 Cultural and Linguistic Competence

C.10.2.1 The Provider shall ensure culturally competent services that ensure staff and foster parents understand and are familiar with the youth's culture, reinforce positive cultural practices, and acknowledge and build upon ethnic, socio-cultural and linguistic strengths. The Provider shall endeavor to employ staff and recruit foster parents representative of the community served.

C.10.2.2 The Provider shall have the capacity to provide linguistically competent services through staff that are fluent in the languages spoken by the children and youth being served, or from another source providing such services. The Provider shall have the capacity to serve hearing impaired clients.

C.10.3 Community-Based Services

C.10.3.1 The Provider shall support children and youth in maintaining connections with schools, churches, friends and families, as appropriate. The Provider shall develop and maintain linkages that strengthen the relationship with the child/youth's home communities, and/or the community in which he/she may be residing upon discharge.

C.10.3.2 The Provider shall develop a community-based network of services and affiliations that will facilitate supportive services for children/youth and their families in the community of origin, community of placement, and/or community where a potential kinship care or family-based foster care provider resides.

C.10.3.3 The Provider shall implement a model or practice that supports children and youth in becoming involved in community-based services.

C.10.3.4 The Provider shall ensure that children and youth develop skills for living successfully in the community. Foster parents shall make community resources available to children and youth, and encourage participation and involvement in community based programming. Volunteer

civic activities, use of public agencies/services such as the local library and health clinic, and recreational activities at a local gym or community center are some examples of such skills. The Provider shall include a description of the model for developing community connections in its business plan, and the community resources it plans to utilize.

C.10.3.5 The Provider shall ensure that every child or youth has an opportunity to participate in religious services of his/her choice, or to refrain from religious practice if so desired. The Provider shall ensure foster parents make meal choices or alternatives available that respect the religious practices of children and youth.

C.10.3.6 The Provider shall link children or youth with organizations that can provide education and support services for any gay, lesbian, bisexual, transgendered and questioning children and youth in need of these services.

C.10.4 Transportation

C.10.4.1 The Provider shall ensure transportation for children/youth to all:

C.10.4.1.1 Routine and emergency medical and mental health appointments;
C.10.4.1.2 Daily school/educational, extra-curricular and vocational activities;
C.10.4.1.3 Recreational activities;
C.10.4.1.4 Community activities;
C.10.4.1.5 Family activities and visits;
C.10.4.1.6 Reviews, court appearances, and conferences.

C.10.4.2 The Provider shall ensure vehicles include all safety devices required by law. The Provider shall submit upon request of the Contracting Officer copies of vehicle registrations and inspections, if applicable.

C.10.4.3 The Provider shall ensure that its transportation protocol includes provisions for safe transport and transfer of children and youth from the care and supervision of one approved adult to another. Such protocol should include documented signature by the individual(s) relinquishing supervision of the child or youth for the purposes of the transport, the individual(s) assuming supervision post-transport, as well as the signature and identity of the transportation carrier and driver.

C.10.5 Mandatory and Unusual Incident Reporting

C.10.5.1 The Provider must report any alleged child abuse, neglect or other risk to residents' health and safety to the CFSA Hotline (202-671-SAFE).

C.10.5.2 The Provider shall follow the procedures and requirements outlined in 29 DCMR Chapter 60 licensing regulations for mandatory reporting of unusual incidents, and in accordance with CFSA policy. The Provider must also file an unusual incident report any time the resident and/or staff has engaged in an event that is significantly distinct from normal routine or procedure of the resident, the program, the staff, or any person relevant to the resident.

C.10.6 Quality Assurance and Data Collection Requirements

C.10.6.1 The Provider shall develop and maintain a quality assurance system that collects and assesses, at a minimum, the data indicated in Section B outlining the Modified Scorecard specifications, and in Section C.3 Performance Indicators and Outcomes. As part of its business plan, the Provider shall submit an overview of its quality assurance and/or continuous quality improvement system. CFSA will monitor this system and data pertinent to the quality of care of CFSA children and youth.

C.10.6.2 The Provider shall work collaboratively with CFSA in further development of indicators and outcome measures in the areas of safety, permanence and well being.

C.10.6.3 The Provider shall make its quality assurance system and data available for CFSA review, and respond to any data requests made by CFSA in regard to children and youth cared for as per this agreement.

C.10.6.4 The Provider shall comply with the requirements for progress note documentation regarding children and youth placed by CFSA (see Section C.10.7 for details of documentation requirements).

C.10.7 Recordkeeping and Documentation Requirements

C.10.7.1 The Provider shall ensure that all child and family information and documentation is entered into the FACES system and the case record. The CMSW shall input completed case plans, case and progress notes, documentation of required visits, and service plans and updates on all aspects of the case.

C.10.7.2 The Provider shall establish and maintain an up-to-date paper case record on each child or youth in its care that stores the case plan information, to include all aspects of service planning, treatment, progress notes, and other information pertinent to the child or youth in a manner conducive to managing care and audit review.

C.10.7.3 The Provider shall ensure that monthly reviews and updates to the ISP/ITILP include detailed notes on the child or youth's progress, and/or lack thereof, for inclusion in the case plan and case record.

C.10.7.4 The Provider shall submit to CFSA's Business Services Administration (BSA) all case and progress notes on case management, treatment and service delivery that fully outline the care provided to children and youth. On a monthly basis, the Provider shall include summary notes on dates of service, the service providers and their credentials, the nature and extent of the service, duration of the service, units of service, and locations of service. The documentation submitted should include at a minimum the following information each time a service is rendered:

C.10.7.4.1 Name of child/youth;
C.10.7.4.2 Child's Medicaid number or other identifier;

C.10.7.4.3 Child's Social Security Number
C.10.7.4.4 Name of provider and credentials/qualifications;
C.10.7.4.5 Date of service;
C.10.7.4.6 Location of service;
C.10.7.4.7 Type of service, i.e. Client Intake, Assessment, Case Planning, Service
C.10.7.4.8 Coordination and Monitoring and Case Plan Reassessment;
C.10.7.4.9 Duration of service;
C.10.7.4.10 Progress notes describing what service was provided, why the service was provided and indicating how the service or intervention is assisting the child/youth in meeting their case plan goals;
C.10.7.4.11 Other notes as required by scope of practice.

C.10.7.5 The Provider shall ensure that all case notes remain in the child's treatment folder as part of the case record; and submit another copy with the invoice for services.

C.10.7.6 The Provider shall adhere to Medicaid regulations that require each claim to Medicaid include a Medicaid enrolled child/youth; a provider that meets Medicaid eligibility as a licensed provider of the healing arts or under the supervision of a licensed provider if allowed in the District as part of the scope of practice; and be a Medicaid eligible service.

C.10.8 Information Management System Requirements

C.10.8.1 The Provider shall meet the following hardware and software requirements specified by CFSA's Child Information Systems Administration (CISA) for the purpose of meeting the data collection and documentation requirements outlined in Sections C.10.6 and C.10.7.

C.10.8.1.1.A Hardware

1. Intel Pentium® 4 CPU 2.00 GHz or above, 512 MB RAM PC/Laptops
2. Display Adapter Supporting 1024 x 768 Pixels
3. 108 Keyboard, Mouse
4. High Speed internet connection (e.g. Cable Modem, DSL etc)

C.10.8.1.1.B Software

1. Operating systems should be Windows XP Service Pack 2/ Windows Pro 2000 SP4/ Windows XP Home Edition
2. Internet Explorer 6 Service Pack 1
3. Adobe Acrobat Reader 7.0
4. Either Microsoft Office 2003 or Word Viewer
5. Fax Viewer (Windows Fax Viewer) – only required for those PCs that need to view scanned documents.

C.10.8.2 FACES.NET Access and Information

C.10.8.2.1 The Provider is required to maintain updated placement and foster home information in

FACES.NET that allows placement staff to access pertinent information electronically.

C.10.8.2.2 The Provider shall ensure that all staff responsible for managing FACES information participate and complete training initial and ongoing FACES.NET training, and have access to the security level necessary to perform his or her job.

C.10.8.2.3 The Provider shall ensure that each CMSW, and respective Social Work Supervisor, responsible for data entry of case management and foster home information into FACES have access to the computer hardware and software requirements.

C.10.8.2.4 The Provider shall ensure that FACES.NET is the information system of record for all case data as well as quality assurance, outcomes and scorecard measures.

C.10.8.2.5 The Provider shall enter all contact/case notes pertaining to social work service delivery into the CFSA information system within 72 hours of completion of an activity. The case notes shall adhere to specifications outlined in Section C.10.7 on Recordkeeping and Documentation.

C.10.8.3 Technology Support

C.10.8.3.1 The Provider shall have the capacity for technology support via staff with expertise in the FACES.NET application and management of on-line reports. These staff shall be responsible for providing functional assistance to its own agency staff, and participate in CFSA design sessions and enhancement meetings.

C.10.9 Business Plan and Budget

The Provider shall develop a written business plan that addresses and fully describes how the tasks and requirements specified in this HCA will be accomplished. The business plan shall include a detailed budget that includes all costs associated with operating the program.

C.11 APPLICABLE DOCUMENTS

The following documents are incorporated in this solicitation and resulting Human Care Agreement by this reference:

Item No.	Document Type	Title
1	DC Municipal Regulations	**29 DCMR, Chapter 60**
2	DC Municipal Regulations	**29 DCMR, Chapter 16**
3	CFSA Policy	**CFSA Out-of-Home Practice Protocol located at http://newsroom.dc.gov/show.aspx/agency/cfsa/section/2/release/18245**
4	CFSA Administrative Issuance	**CFSA-09-21 Education Assessment located at http://cfsa.dc.gov/cfsa/cwp/view,A,1418,Q,644381,cfsaNav_GID,1765,.asp**

REVISED ATTACHMENT J.1.3
DEFINITIONS OF PROVIDER SCORECARD MEASURES

REVISED ATTACHMENT J.1.3

DEFINITIONS OF PROVIDER SCORECARD MEASURES

SECTION B	MONTHLY MEASURES	DEFINITION
B.10.2.1	In-Home Visitation (50%)	Case Managing Social Worker (CMSW) shall make at least twice-monthly visits to any children that are remaining in the natural home. At least one visit per month shall be in the home, but the second may occur elsewhere.
B.10.2.2	Foster Care Visitation (80%)	Case Managing Social Worker (CMSW) shall make twice-monthly visits to each child placed in family-based foster care. At least one visit per month shall be in the home, but the second may occur elsewhere. (*Note: The CMSW shall assess the safety of each child at each visit, and ensure that the child is interviewed separately at least monthly outside the presence of the caretaker).
B.10.2.3	Sibling Visitation (75%)	Children placed apart from their siblings shall have at least twice-monthly visitation with some or all of their siblings.
B.10.2.4	Parent-Child Visitation (85%)	Children with a goal of reunification shall visit with their parents on a weekly basis, unless clinically inappropriate and approved by the Family Court.
B.10.2.5	First 4 Weeks Visitation (90%)	Case Managing Social Worker (CMSW) shall make weekly visits with children in a new or changed placement setting for four consecutive weeks (See *Note above for safety assessment requirements).
B.10.2.6	Health Screenings (90%)	Case Managing Social Worker (CMSW) shall ensure a pre-placement health screening takes place for each child.
B.10.2.7	Placement Stability (80%)	Provider shall ensure that children do not incur more than two foster care placements while being case managed by that particular Provider's agency.
	QUARTERLY MEASURES	
B.10.2.8	No Re-Entries within 12 (96%)	The percentage of children discharged from foster care to reunification that have not "re-entered" the abuse/neglect system within 12 months of a prior foster care episode.
B.10.2.9	Achieving Permanency within the past 12 Months (80%)	The percentage of children having achieved permanency (reunification, guardianship, adoption) within the past twelve (12) months.